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ABSTRACT

One of a series designed to help Florida school districts provide special programs for exceptional children, the training packet is intended to be used in a 2-day training session for school bus drivers who transport handicapped students. The manual includes a brief introduction to five disability areas (physical impairments, visual impairments, hearing impairments, mental retardation, emotional handicaps) and implications of each for school bus management. In addition, five other topics are addressed: communication with families; medical aspects of disabilities; legal issues of school bus drivers; management of seizures; and lifting, carrying, and transferring the handicapped student. Each topic includes instructions for conducting the training session and many also provide a list of references on the topic. (CL)

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TRAINING MANUAL

for

SCHOOL BUS DRIVERS TRANSPORTING the HANDICAPPED

Florida Department of Education
Division of Public Schools
Bureau of Education for Exceptional Students

EC 162415

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DIVISION OF PUBLIC SCHOOLS
BUREAU OF EDUCATION FOR EXCEPTIONAL STUDENTS

Florida Department of Education Publications in Exceptional Student Education

The following is a list of publications developed by the Bureau of Education for Exceptional Students to assist local school systems in the provision of special programs for exceptional students. For additional information, please contact:

Mrs. Linda D. Schroeder, Consultant
FDLRS Clearinghouse/Information Center
Florida Department of Education
Bureau of Education for Exceptional Students
Knott Building
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RESOURCE MANUALS

Laws and Rules

___ Volume I-B: Florida Statutes and State Board of Education Rules: Excerpts for Programs for Exceptional Students, 1982.

___ Volume I-C: Federal Laws and Regulations Pertaining to the Education of Exceptional Students - P.L. 94-142, Sec. 504, and P.L. 89-313, 1982.

___ Volume I-E: Florida Statutes and State Board of Education Rules: Florida School for the Deaf and the Blind - Florida Department of Health and Rehabilitative Services, 1980.

Program Manuals

___ Volume II-A: Visually Impaired

___ Volume II-B: Mentally Handicapped, 1982.

___ Volume II-C: Speech and Language Impaired, 1979.

___ Volume II-D: Hearing Impaired: Deaf and Hard of Hearing

___ Volume II-E: Emotionally Handicapped, 1981.

___ Volume II-F: Specific Learning Disabilities, 1980.

___ Volume II-G: Gifted, 1980.

___ Volume II-H: Homebound/Hospitalized, 1980.

___ Volume II-I: Physically Impaired, 1977.

___ Volume II-J: Occupational and Physical Therapy, 1982.

___ Volume II-K: Deaf-Blind, 1982.

(continued on inside back cover)

PREFACE

The training packet for school bus drivers who transport the handicapped is designed to assist persons who are responsible for providing the training with a consistent format for updating driver skills. The format has been field tested and refined over a two year period to determine its effectiveness in meeting training needs.

The two day training session is intended to give an overview of the characteristics of exceptional students who cause the greatest concern among school bus drivers and to introduce related topics concerning driver responsibilities.

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A GUIDE TO INSERVICE FOR SCHOOL BUS DRIVERS TPANSPORTING HANDICAPPED CHILDREN

INTRODUCTION

Transportation of handicapped students has become a major concern of bus drivers and educators during the last decade. From 1968 to 1973, as school districts geared up to meeting the legislative mandate to serve all handicapped children, drivers were faced with new challenges and new opportunities as bus routes were adapted and adjusted to meet the needs of handicapped students. Shuttle buses were often utilized to deliver the child in a wheelchair to his assigned school. Special accommodations had to be made for the deaf student, especially the very young child, to arrive at his destination safely. Blind children presented another set of concerns, especially since some of the handicapped population need to be served out-of-county to receive an appropriate education.

Much of the trauma of providing transportation for the growing handicapped population has subsided after several years of experience. Drivers have developed many skills along the way which have allowed them to safely and efficiently transport these students. They have also recognized the need for assistance in meeting the challenge of both providing services to the severely handicapped and providing these services at an earlier age. Transportation of these students, some of whom have a two hour/one way bus ride, requires school bus driver and school bus driver aides to have many of the same competencies which a classroom teacher or teacher aide must have at the school. The yellow school bus can and should be an extension of the school environment which serves as a learning experience for students who, during the 1960's, would have probably been confined almost exclusively to their home environment.

In an effort to respond to the request of school bus drivers for training which would make them more responsive to the needs of the handicapped youngsters they transport, and to recognize drivers as an integral part of the education team, this training module has been developed. It is designed to provide school district personnel with a pattern whereby they can update the skills of school bus drivers who transport the exceptional student.

OVERVIEW

This Resource Manual for School Bus Drivers of the Handicapped contains a brief introduction to each of the areas of exceptionality which are included in the agenda in addition to resources which are recommended for supplementary information and a discussion outline. The exceptionalities which are addressed in the manual are not, however, all inclusive. Most of the students who are being served in special

programs do not require any significant adaptation of their environment or any singling out from the student who is served full-time in the regular classroom while they are being transported. For that reason, only students who have physical disabilities, including the deaf and the blind students, students who are moderately, severely, or profoundly mentally handicapped or students who have severe emotional handicaps are the focus of this training package. These are the students who cause the school bus driver and the school bus driver aide the greatest concern on the ride between the home and the school. These are the students who need a hydraulic lift bus to safely board the bus. These are the students who may endanger the safety of other passengers by their acting out behavior. These are the students who cannot hear and need to sit very near the driver so that communication can take place. These are the students who cannot see who need to sit in in the same place every day so that they can be independently mobile. These are the students who can benefit from having a school bus driver who is aware of their special needs and knowledgeable about their handicapping condition.

Also included in the training manual are five special topics. These became part of the session because of specific needs which were expressed by school bus drivers during the pilot training sessions.

One special topic, Medical Aspects, gives some basic information regarding contagious diseases, effects of some of the major medications and some do's and don'ts regarding medical intervention. Another topic deals with the legal responsibilities of the driver and is designed to specify some of the ways in which the school bus driver can protect himself/herself against being legally liable for accidents or injury.

A separate section is devoted to handling seizures. While this is a medical problem and also one which is often covered in the first aid courses, it is singled out for this training because it is significant enough for a separate training session. Lifting, carrying, and transferring is a fourth special topic relating exclusively to the student who has an orthopedic handicap.

Finally, directions for conducting a simulated exercise, "Working With Families," is also included. This is designed to give insight into the ways in which better communication can be established between the school bus driver and the home environment.

The overall objectives of the training session for school bus drivers and school bus drivers aides are:

1. To provide an awareness of some of the characteristics of students who are physically impaired, visually impaired, hearing impaired, mentally retarded or emotionally handicapped.

2. To develop skills in communicating effectively with families.

3. To provide an awareness of some of the medical aspects and the legal responsibilities of school bus drivers.

4. To develop skills in handling seizures and lifting, carrying and transferring the handicapped student.

The need for additional training should not be overlooked. Behavior modification techniques, effective communication with school based personnel and enroute activities as an extension of the school day are some of the topics projected for subsequent training sessions.

OUTLINE
SCHOOL BUS DRIVER TRAINING PACKET

The packet for the training session for school bus drivers who transport the handicapped includes a training manual, video tapes and audio tapes as follows:

1. Training manual

   a. A discussion outline for the major topics
   b. Suggested resource persons for each major topic (by descriptor, i.e., public health nurse)
   c. Resource materials available
   d. Suggested handouts
   e. A tentative agenda
   f. Pre-test and post-test
   g. Evaluation form

2. Video tapes

   a. Tape 1: Introduction to the Training Session — Landis M. Stetler
      The Student who is Physically Impaired — Patricia A. Hollis
      The Student who is Visually Impaired — Marie K. Kreimer
      The Student who is Hearing Impaired — Gladys Crawford
   b. Tape 2: The Student who is Mentally Retarded — Evelyn Syfrett
   c. Tape 3: The Student who is Emotionally Handicapped — Diana Wells
   d. Tape 4: Legal Issues in Transporting the Handicapped — William Ploss
   e. Tape 5: Lifting, Carrying and Transferring the Handicapped — Mary Bowers

3. Audio tapes transcribed from video tapes as above for use when video equipment is not available or when video presentation is not possible as with a very large group.

The training films recommended for use, "Lifeline to Learning" and "Problems in Transporting the Handicapped" are available from the Clearinghouse/Information Center, Department of Education, Knott Building, Tallahassee, Florida 32304 and from the Department of Education, School Transportation Section, Knott Building, Tallahassee, Florida 32304.

The film "Images of Epilepsy" recommended for the presentation on handling seizures is available from the local chapter of the Epilepsy Foundation or from the Florida Epilepsy Foundation, 438 West Brevard Street, Tallahassee, Florida 32301.

PERSONS PRESENTING ON VIDEO-AUDIO TAPES

Mary Bowers, R.P.T.
Leon County Schools

Gladys Crawford, Consultant
Hearing Impaired
Bureau of Education for Exceptional Students

Patricia A. Hollis, Consultant
Physically Impaired, Homebound/Hospitalized
Bureau of Education for Exceptional Students

Marie K. Kreimer, Consultant
Visual Disabilities
Bureau of Education for Exceptional Students

William Ploss, Lawyer
Florida Bar Association

Landis M. Stetler, Bureau Chief
Bureau of Education for Exceptional Students

Evelyn Syfrett, Consultant
Mental Retardation
Bureau of Education for Exceptional Students

Diana Wells, Consultant
Emotionally Handicapped
Bureau of Education for Exceptional Students

DIRECTIONS FOR USING THE TRAINING PACKET

The training is designed to be conducted in one hour blocks as indicated on the Tentative Agenda (see Appendix). Five of the topics have an accompanying introductory video tape or alternate audio tape if a video presentation is not feasible. These are:

Tape 1: Introduction to the Training Session
The Student who is Physically Impaired
The Student who is Visually Impaired
The Student who is Hearing Impaired

Tape 2: The Student who is Mentally Retarded

Tape 3: The Student who is Emotionally Handicapped

Tape 4: Legal Issues in Transporting the Handicapped

Tape 5: Lifting, Carrying and Transferring the Handicapped

Tape 1 can be viewed as a single unit or presented as separate topics with a discussion period following each topic. Each topic presentation should consist of:

1. Video or audio tape introduction, where available
2. Presentation by discussion leader as a follow-up to the introduction
3. Discussion period

In presenting topics which do not have introductory tapes, the manual includes a discussion guide with specific suggestions for conducting the session. The manual is intended to serve as a resource for each presentation to provide the person(s) providing the training and the discussion leaders with background information and suggested content for all topics. References and resources have been included whenever possible.

Each topic presentation in the manual is followed by a section on Conducting the Session. This section includes recommendations for the selection of discussion leaders and additional general information.

The training session coordinator should be aware of the need for well informed resource persons to serve as discussion leaders for each topic. The role of the coordinator becomes one of scheduling all discussion leaders, informing them of the purpose of the training, and making them aware of the type of material which is appropriate for their presentation and discussion with the group. The coordinator can additionally assume the role of identifying needs for further training while this session is being conducted and acting as overall coordinator in managing the training.

General Considerations:

A pre-test and post-test are included in the Appendix. The pre-test can be administered either before or after the first film, "Lifeline to Learning." The post-test should be administered immediately after the session on "Lifting, Carrying and Transferring the Handicapped Student."

The evaluation form (in Appendix) should be completed by each participant at the end of the session. This will provide the necessary information to revise and update the training manual. If the training coordinator so wishes, the Department of Education would appreciate receiving a copy of the final report.

Participants should be urged to make recommendations for future training needs. This is an important function of the entire training session and each topic should be explored for possible expansion, clarification or revision.

The training is designed as a two-day program. Although it can be encapsulated into a single day, this is not recommended. The discussion period is a most important part of the training and this would need to be significantly shortened if the training were attempted in one day.

Please forward any suggestions for improving the product directly to:

Patricia A. Hollis, Consultant
Physically Impaired, Homebound/Hospitalized
Bureau of Education for Exceptional Students
Knott Building
Tallahassee, Florida 32304

THE STUDENT WHO IS PHYSICALLY IMPAIRED

State Board of Education Rule 6A-6.3015(1) identifies this population as "one who has a physically disabling condition or other health impairment and such condition requires an adaptation in the student's school environment or curriculum." The student may have sensory, perceptual and/or social-emotional developmental deficits in addition to physical impairments.

The majority of the students who are served in programs for the physically impaired in the public school are there because of the severity of their handicap. Many students who are mildly handicapped are served in regular classrooms and have little if any difficulty adapting to the school environment.

There are a variety of conditions and illnesses which may require that a student be placed in a special class. Many of these conditions are identifiable at birth. Doctors have become more skillful in the last fifteen years in saving lives of infants with congenital handicaps and most of them are able to function well with the help of braces, crutches, wheelchairs or some other device. Others may have chronic conditions which make them highly susceptible to respiratory ailments or other infections. All of them are able to benefit from an educational environment and have the right to an appropriate education just as any other student.

Many students enrolled in special programs for the physically impaired need to receive occupational therapy or physical therapy or both. Occupational therapy prepares the student to deal with his/her environment more adequately. Physical therapy teaches the student to use his/her existing physical abilities to the greatest possible extent.

Teacher, teacher aides and other school personnel can be an invaluably resource to the school bus driver. By sharing information, the teacher and the driver will find ways to make a student's total school day, i.e., hours spent away from home, a more meaningful and enriching experience. Only by cooperative efforts of all adults who interact with the student can real learning take place. What happens, or what does not happen, on the yellow school bus is an integral part of that learning.

A few of the most common physical conditions are described below.

Cerebral Palsy:

The most common physical disabling condition is cerebral palsy, which means literally "brain paralysis," indicating a malfunction or damage to the brain. The paralysis occurs during pregnancy or at the time of birth in 86% of the cases. Of the remainder, cerebral palsy is the result of injury to the brain from any of a number of possible causes, brain tumor, brain hemorrhages, skull fractures, etc.

Cerebral palsy is classified according to the movement and according to the limb involvement. Hence, one student who is cerebral palsied might be spastic diplegic, translated as a person whose movements in the affected limb(s) are jerky and uncontrolled. For a diplegic, jerky muscles would be very noticeable in lower limbs and perhaps slightly noticeable in the upper limbs. Another student with cerebral palsy might be athetoid monoplegic, athetoid meaning that movements of one limb (monoplegic) are involuntary and purposeless.

There are many other classifications of movement and limb involvement which will not be described here. The purpose of giving the above examples is only to indicate that cerebral palsy is a condition which can be evidenced in a number of ways and that merely to know that the student who rides School Bus 87 is cerebral palsied does not give you any real knowledge of his condition; nor are the medical terms important. What is important to know is that a student described as ataxic hemiplegic will fall often and should be watched carefully because these children have a very poor sense of balance.

What does this mean for the school bus driver?

1. Sudden movements and loud noises should be avoided since they may aggravate movement disorders especially with the child with spasticity.

2. The position of the child should be changed frequently with long periods of sitting avoided. In addition to the child's comfort, this is important to prevent pressure sores on the buttocks and muscle tightness from being in one position.

3. When the child is sitting, he should be properly supported and in good body alignment. Pillows, blocks or other aids may be used to maintain good position of legs, trunk and head.

4. The child should be expected to do as much as possible for himself in all areas including self-care, mobility, and academic skills.

5. Seat belts and safety harnesses are a necessity for children with poor trunk control.

6. Communication skills must be practiced. Suggestions can be provided by the speech therapist.

Spinal Defects:

Other conditions which are quite common in the physically impaired population is myelomeningocele, spina bifida and meningocele. These are conditions which exist at the time of birth and they are characterized by the spinal cord or canal defects. These are handicapping conditions which usually require surgery within twenty-four hours of birth to save the life of the infant.

While there are many differences in the effects of the three spinal disorders, myelomeningocele is the most serious in that it causes paralysis of the lower limbs and trunk below the damaged area of the spine. The implications of this are apparent. Since, in addition to paralysis, there is a complete loss of skin sensation to pain, temperature and touch in the paralyzed area, these students must be protected against injury in the affected parts and must shift their sitting position frequently. These students also have a bladder and bowel paralysis which can require tact and consideration in handling embarrassing situations. Hydrocephalus, known as water on the brain, is present in 90-95% of the children with spinal defects such as myelomeningocele. Permanent drainage systems are used to treat this condition and the system, called a shunt, must be watched so it does not become dislodged or injured.

Implications for School Bus Management

1. The child should be guided and encouraged to become independent in ambulation, self-care, brace management, and wheelchair mobility.

2. The child should be reminded to check for blisters or redness on insensitive skin. If the child is too young or unable to do this for himself, the bus driver should check regularly so pressure sores can be prevented. Sheepskin, water pillows and other aides may be useful in relieving pressure areas during long bus rides.

3. If ambulation is not realistic due to the severity of involvement, low motivation, or associated impairments, training should focus on independent transfers to and from the wheelchair and the ability to perform normal daily activities from the wheelchair.

4. Proper positioning procedures should be followed to maintain good alignment of legs and trunk and to prevent pressure sores. Long periods of staying in one position should be avoided.

5. Mental functioning is usually unimpaired by this condition.

Cystic Fibrosis:

Cystic fibrosis is the most common cause of death from a genetic disorder in the United States. It is also the most common cause of chronic lung disease in Caucasian children. In Florida, there is a high incidence of cystic fibrotic children because parents of these children tends to move to the warmer climate.

This disease is characterized by an abnormally thick, viscid mucus being secreted into organs in the body. This is found to especially affect the lungs, causing difficulty in breathing and a low resistance to infection. These students need to be protected from situations which would cause infection: drafts, cold, or other students who might be infectious.

What does the school bus driver need to know about the student with cystic fibrosis.

1. The driver should be aware of all treatment measures for a child with cystic fibrosis including diet, medications, and respiratory treatment.

2. The child may require frequent snacks during the day.

3. When possible, exposure to infections should be minimized. Immunizations are extremely important to prevent illnesses.

4. It may be necessary to limit activity due to respiratory insufficiency under stress conditions. Caution should be exercised to prevent the child from overheating or becoming chilled.

5. The child must be closely followed by a physician which should be arranged by the child's parents.

Muscular Dystrophy:

Another disease which we consistently find in public schools is muscular dystrophy which causes a progressive diffuse weakness of all muscle groups. Boys are mainly affected and inheritance patterns can be demonstrated in families. Muscular dystrophy is characterized by awkward, clumsy movements. Students with this disease tire easily and are usually obese. As the disease progresses, they become non-ambulatory and lethargic. Transporting the muscular dystrophy student poses a problem in lifting and carrying because of their size and weakness.

What does this mean for the school bus driver?

1. The child should be encouraged to be as active as possible. However, strenous exercise should be avoided at all times.

2. All persons working with the child should be aware of the deteriorating course of the disease and the increasing debility that results. Statements such as "you could do it last week, why can't you do it now" should be avoided.

3. As the child becomes wheelchair-bound, he may require assistance in transferring to and from the chair. Proper body mechanics should be followed to avoid injury. If the mechanical lift is necessary, safety procedures should be followed during its operation.

Osteogenesis Imperfecta:

Osteogenesis imperfecta, or brittle bone disease, is a hereditary ailment. Once again, students who are afflicted require special care in lifting and carrying. Bones can be broken by the most minor bump or twist.

Implications for School Bus Management

1. The level of physical activity for the child should be stated by the child's parents. At all times, rough play is to be avoided.

2. The child with osteogenesis imperfects congenita, the most severe form may require the use of a wheelchair and proper wheelchair management procedures should be followed.

3. The driver must be alert to the possibility of fractures and should remember that fractures may occur spontaneously in these children.

4. If the driver believes a fracture may have occurred, the child should not be moved until the parents can be contacted. Parents should advise all personnel of the procedures to be followed.

5. The driver should be alert to the possibility of a gradually developing hearing impairment.

6. Since most children with osteogenesis imperfecta have normal intelligence, they should be participating in a progressive academic program.

Hemophelia:

Another relatively rare but potentially hazardous condition for the school bus driver is hemophilia. This disease is characertized by the inability of the blood to clot properly or not at all. An individual with hemophilia may bleed profusely from minor cuts or scrapes or even more dangerous may bleed internally from a small bump or bruise.

Implications for School Bus Management

1. The child should be encouraged to be as active as possible without taking unnecessary risks. Strenous physical activities must be avoided.

2. The bus driver should be alert to minor bumps or bruises that might trigger a massive bleeding episode and should be aware of the development of limited and painful movement of the joints, blood in the urine, or signs of intracranial bleeding including headache, dizziness, visual problems, and muscle weakness.

3. Because of anti-coagulant properties, aspirin should never be given to a child with hemophilia.

A written outline of necessary procedures should be prepared by the parents and distributed to all persons working with the child. This should include the parents' phone number and also the phone number of the physician in the event that the parents are not available.

Many more examples could be given of specific conditions or illnesses which require the school bus driver to take special precautions or make particular accommodations for the passengers. But more than knowledge about his charges and their physically disabling conditions, although this is obviously very important, the school bus driver must have understanding and the ability to allow these special students to do as much as possible for themselves and to develop independence despite their weaknesses.

CONDUCTING THE TRAINING SESSION

There are a number of persons who could conduct the discussion on this topic. A teacher of the physically handicapped, an occupational therapist or a physical therapist would all have the background as well as the experience to go into more detail and to answer specific questions. Care should be taken not to dwell on the medical diagnoses but rather to emphasize those aspects of the environment which must be altered to meet the needs of the students.

It would be helpful to have pamphlets and other materials available for this session. The local chapters of the Muscular Dystrophy Association, the Cystic Fibrosis Association, etc., all have reading material available which will be helpful to workshop participants.

The discussion leader may want to explore the possibility of having a student(s) or an adult, who has cerebral palsy or some other handicapping condition, present during the discussion. This person could briefly discuss some of the difficulties which must be overcome by a person who is physically disabled.

The film, "Lifeline to Learning," will have been viewed by the group. Reference should be made to the students in the film who are physically handicapped, such as the "little girl who was able to crawl on the bus." No attempt should be made to diagnose her condition. Rather, she should be pointed out as an example of allowing a person to be as independent as possible.

Questions of a medical nature invariably arise during this discussion period. These need not be answered if the discussion leader does not feel comfortable with the topic. A list of questions can be compiled and discussed at the session on Medical Aspects.

Some determination should be made as to future training needs as the discussion period ends.

REFERENCES

Cooley, K. M. (Ed.). *A Resource Guide for Educators of Physically Impaired and Multiply Handicapped Children.* State of Florida, The School Board of Palm Beach County, 1976.

Florida State Department of Education: Bureau of Education for Exceptional Students. *A Resource Manual for the Development and Evaluation of Special Programs for Exceptional Students - Volume II-I: Physically Impaired,* 1976, pp. 1-62.

South Carolina Department of Education: Office of Programs for the Handicapped. *Guidelines for the Implementation of Programs for Pupils Who Are Orthopedically Handicapped,* 1975.

American Cancer Society, Inc., 219 East 42nd Street, New York, New York 10017.

American Diabetes Association, 1 West 48th Street, New York, New York 10020.

American Heart Association, 44 East 23rd Street, New York, New York 10010.

American Lung Association, 1740 Broadway, New York, New York 10019.

American Occupational Therapy Association, 6000 Executive Boulevard, Rockville, Maryland 20852.

American Physical Therapy Association, 1156 15th Street, N.W., Washington, D.C. 20009

Committee for the Handicapped, People-to-People, 1028 Connecticut Avenue, N.W., #610, Washington, D.C. 20036

Council for Exceptional Children, 1920 Association Drive, Reston, Virginia 20091.

Cystic Fibrosis Foundation, 3379 Peachtree Road, N.E., Atlanta, Georgia 30326.

Muscular Dystrophy Association of America, Inc., 810 Seventh Avenue, New York, New York 10019.

National Paraplegic Foundation, 333 North Michigan Avenue, Chicago, Illinois 60601.

National Cystic Fibrosis Research Foundation, 3379 Peachtree Road, N.E., Atlanta, Georgia 30326.

National Easter Seal Society for Crippled Children & Adults, 2023 W. Ogden Avenue, Chicago, Illinois 60612.

National Hemophilia Foundation, 25 West 39th Street, New York, New York 10018.

National Multiple Sclerosis Society, 257 Park Avenue South, New York, New York, 10010.

United Cerebral Palsy Association, Inc., 111 Wilshire Boulevard, Los Angeles, California 90017.

THE STUDENT WHO IS VISUALLY IMPAIRED

There is a very distinct difference between a student being visually impaired and a student being "blind." The label "visually impaired" includes both partially sighted and legally blind in its definition. The difference is in the amount of measurable vision each person has. A partially sighted student is one whose vision, after the best possible correction, although impaired, is yet a primary channel of learning and who, with considerable adjustments, is able to perform the visual tasks required in the usual school situation. A student who is legally blind is one who, after the best possible correction, has a central visual acuity of 20/200 or less in the better eye or whose visual field subtends an angle of 20° or less.

Most partially sighted and many legally blind students will need little or no assistance. However, there are some general rules to follow with these students.

Always try to get information as to what the problem is with the student's vision (acuity, loss of field of vision, detached retina, etc.).

Most common eye problems:

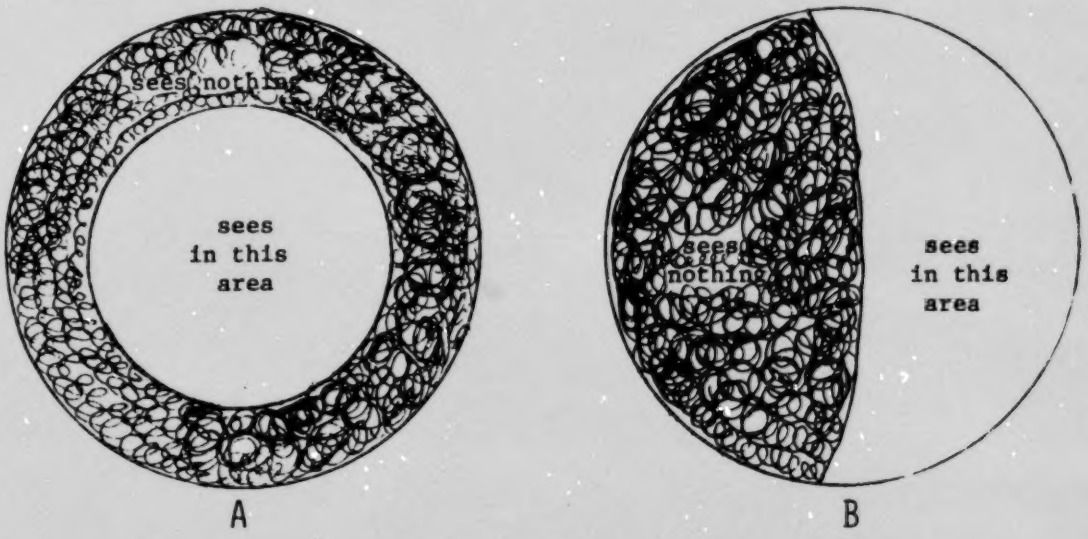
1. Low acuity - The student will see everything but will see it as as if through a mist. They will not be able to read street signs, house numbers, or in some instances, be able to differentiate one house from another.

2. Loss of field of vision - The student will have "blind spots." What he does see he may see clearly but may have to turn his head from side to side or may only see a small area in the middle of his eye.

   Examples:

   A. Tunnel Vision (Retinitis Pigmentosa) or Advanced Glaucoma

   B. Detached Retina



A B

General Considerations:

1. The visually impaired student should be placed as close to an exit door as is possible to allow access without having to ask for special help or to grope over obstacles such as books and other students.

2. Seat all blind students in the same seat each day. This should be near the door so that the driver can inform the student when his stop is reached.

3. On the first day, show the blind student where his seat will be and allow him to walk from the door to the seat and back several times until he has mastered this route.

4. Speak directly to the visually impaired child and use his/her name when communicating.

5. Some visually impaired students are very sensitive to light and should not be placed by a window.

6. A student with a detached retina should not be allowed to have hard knocks or jolts, especially to the head area, as this may cause "total" blindness.

CONDUCTING THE TRAINING SESSION

The teacher of the visually impaired in the district or in the multi-county region should be invited to lead this discussion. This person will be able to give specific suggestions regarding mobility training.

An opthalmologist or optometrist could also be helpful if more medically oriented information is needed. This might be the case if the incidence of visually impaired students is high.

THE STUDENT WHO IS HEARING IMPAIRED: DEAF AND HARD OF HEARING

Florida Law 6A-6.3013(1) identifies this population as:

"Deaf--one who is born with or acquires prelingually, a hearing loss so severe unaided, that one cannot learn speech and language through normal channels; pure tone average of 500, 1000, 2000Hz, at seventy (70) decibels or more, ANSI, in the better ear.

Hard of Hearing--one who is born with or acquires a hearing loss which may range from mild to severe unaided and whose speech and language, though imperfect, are learned through normal channels; pure tone average of 500, 1000, 2000Hz between thirty (30) and sixty-nine (69) decibels, ANSI, in the better ear."

These students are hearing impaired, but their handicap is in the ability to communicate. We learn to talk through hearing the spoken word. A deaf child must be taught to speak, to learn the meaning of words and to learn how to put words together to make meaningful sentences. Some deaf children also use a form of manual communication. They spell with their fingers and/or use signs for words and sentences.

The hearing impaired student depends on his vision to keep him in contact with his environment. Deafness is seldom total, therefore, most of the students wear hearing aids. A hearing aid only makes sounds louder. It does not make these students have normal hearing. The hearing impaired student is trained to get information by listening, and by watching a speaker's lips and facial expressions and/or hand movements. The hearing impaired child should always be treated as any other child.

HELPFUL HINTS

1. Expect the same good standards or behavior, promptness and courtesy that you have set for other students.

2. Get the student's attention by calling his name before giving him directions.

3. Be sure that the hearing impaired student can see your face when you are giving instructions.

4. Avoid using a loud voice and exaggerated lip movements when talking to the student. He has been trained to lip read normal speech.

5. Be sure that he understands your directions. Repeat when necessary. If he still does not understand, change the wording. He may be having trouble with the meaning of a word.

6. At first the hearing impaired student's speech may be difficult to understand. With listening experience, your ear will become accustomed to the speech.

7. Keep in close touch with the classroom teacher. Report any infringement to the teacher and to the parents.

CONDUCTING THE TRAINING SESSION

The teacher or the hearing impaired in the district or in the multi-county region should be invited to lead this discussion. This person will be able to give specific suggestions regarding lip reading.

An audiologist could also be helpful if more medically oriented information is needed. This might be the case if the incidence of hearing impaired students is unusually high.

THE STUDENT WHO IS MENTALLY RETARDED

The problem of mental retardation within the educational context is an extremely varied and difficult one. In these schools, the student with lowered intellectual ability must function in competition with the student with higher intellectual ability. The question which educators and school bus drivers must respond to is "When do the differences in the student's ability to compete become important enough to require special treatment of some kind, either in the school or on the school bus?"

In order to meet the criteria for special placement in a school program, the student must demonstrate lower functioning in both intellectual activities (I.Q.) and adaptive behavior. A student may be doing poorly in school but be very competent in all other behavior at home, in the community and in all school situations except academic learning. This student should never be considered retarded. Many factors could account for the poor performance academically.

The student who is retarded is one who lacks the skills to effectively interact with his total environment, not just with one segment of his environment. Consequently, his environment must be altered to a small or to a great degree to allow him to function as competently as possible. This alteration of environment includes his learning program as well as his learning style.

The degree of retardation is classified as mild, moderate, severe, and profound as determined by both measured intelligence and adaptive behavior. The level of adaptive behavior generally correlates to some degree with the level of functioning on measured intelligence, because behaviors sampled by current intelligence tests seem to contribute to total adaptation. This means that the mildly retarded individual would not necessarily be singled out as being noticeably different when being transported on the school bus. However, as the condition becomes more severe, it may be necessary to adopt certain methods in order to effectively communicate with a student.

The following case examples are provided to illustrate the levels of retardation and to show how adaptive behavior can vary among individuals. The examples are for chronological age six only, but a similar analysis could be done for other age groups with additional behaviors being used. It should be kept in mind that these are merely examples.

Robbie is a <u>mildly</u> <u>retarded</u> six year old. He has a speaking vocabulary of 300 words and uses grammatically correct sentences. He recognizes advertising words and signs (Eckerds, stop, men, ladies) and relates experiences in simple language. Robbie participates in group activities and interacts with others in simple play (house, store). He feeds himself, but needs help with bathing. He is toilet trained, but has an occasional accident. He is able to skip and hop as well as climb stairs with alternating feet.

Susie is a moderately retarded six year old. She recognizes many of the words and signs in her environment (exit, Texaco) and understands simple verbal communications. Her vocabulary consists of about 200 words, and she occasionally relates her experiences verbally. Susie participates with others in simple group games and expressive activities, and she frequently engages in role-playing (playing house) with others. She feeds herself with a spoon and fork, but she occasionally spills food. She puts on clothing but needs help with buttons and zippers. She is partially toilet trained with infrequent accidents. She climbs with alternate feet and rides a tricycle.

Janie is a severely retarded six year old. She has a ten word vocabulary and communicates her needs with gestures and pointing. She may play with others for short periods of time under direction but does not interact with other children voluntarily. Janie recognizes the significant adults in her environment and has definite favorites. She tries to feed herself with a spoon but usually prefers finger-feeding. She can remove her own shoes and socks but is not able to put on any clothing. Janie will indicate a toilet accident and will occasionally indicate a toilet need. She can walk unassisted and she is able to pass objects to others.

Peggy is a profoundly retarded six year old. She does not speak though she continually vocalizes. She communicates her needs with noises and an occasional gesture. Peggy will play "patty-cake" at times but she generally plays imitatively with no interaction. She is not able to feed herself with a spoon, but she does feed herself with her fingers reasonably well. She does not drink from a cup without assistance. She cooperates with dressing and bathing but cannot put on or remove any clothing. She walks unsteadily and cannot run but her eye-hand movements are reasonably well coordinated. Peggy does not indicate toilet need but will occasionally indicate toilet accident.

From these examples, it becomes evident that the school bus driver must have some information regarding the functioning level of these students.

In general, however, the driver needs to be aware that these students need to be treated as normally as possible, realizing that they will have to have directions repeated often and that their ability to cope with unfamiliar facets of their environment is limited.

CONDUCTING THE TRAINING SESSION

The supervisor of the program for the mentally retarded or a teacher in that program should be chosen to lead this discussion session. These persons would be able to recommend specific techniques for making the time spent on the school bus a profitable learning experience for the students.

A great deal of misunderstanding still exists concerning the retarded. Every effort should be made to stress the fact that the retarded are often not distinguishable from other persons if they are encouraged to function at their own level and accepted as valued human beings. An article written by the school bus driver in Ohio is included in the Appendix (The One Room School Bus). She tells how she created a learning atmosphere on her daily bus route which extended the school day. It might be helpful to have copies of this article available during this session.

THE STUDENT WHO IS EMOTIONALLY HANDICAPPED

The following State Board of Education definition is an attempt to provide an objective definition for emotionally handicapped students:

The emotionally handicapped child is the student who, after receiving supportive educational assistance and counseling services available to all students, still exhibits persistent and consistent severe to very severe behavioral disabilities which interfere with productive learning processes. This is the student whose inability to achieve adequate academic progress and/or satisfactory interpersonal relationships cannot be attributed primarily to physical, sensory or intellectual deficits.

Some of the characteristics of these students are:

1. Short Attention Span - unable to concentrate; not able to pay attention long enough to finish an activity.

2. Restless or Hyperactive - moves around constantly, fidgets; seems to move without a purpose in mind, picks on other children.

3. Does not Complete Tasks - careless, unorganized approach to activities; does not finish what is started, does not seem to know how to plan to get work done.

4. Listening Difficulties - Does not seem to understand - has trouble following directions; turns away while others are talking, does not seem interested.

5. Avoids Participating With Other Children or Only Knows How to Play by Hurting Others - stays away from other children, always plays alone, leaves a group of children when an activity is going on, bites, hits or bullies.

6. Avoids Adults - stays away from adults, does not like to come to adults for attention.

7. Repetitive Behavior - exhibits unusual movement or repeats words over and over, cannot stop activity.

8. Ritualistic or Unusual Behavior - has a fixed way of doing certain activities in ways not usually seen in other children; has an obsessive desire to maintain sameness.

9. Resistant to Discipline or Direction - impertinence, defiance, resentful, destructive or negative, does not accept directions or training, disagreeable, hard to manage, destroys materials or toys deliberately.

10. Inappropriate Conduct Behavior - lying, stealing, use of profanity, masturbation, sex play, undressing, cruelty, running away, etc.

11. Unusual Language Content - bizarre, strange, fearful, jargon, fantasy; very odd or different talk with others or in stories.

12. Speech Problems - Rate - speech that is unusually fast or slow; articulation - difficulty making clear speech, repeating sounds, words or phrases, blocking words or sounds; quality - atonal, flat; voice unusually loud, soft, high or low, scratchy; no speech - chooses not to talk or does not know how to talk so that others can understand.

13. Physical Complaints - Talks of being sick or hurt, seems tired, without energy.

14. Echoes Other's Speech - repeats another person's words without intending for the words to mean anything; failure to use speech for purposes of communication.

15. Lack of Self-Help Skills - unable to feed self, unable to dress self, unable to conduct toilet activities unaided, or to carry out health practices such as washing hands, brushing teeth, etc.

16. Self-Aggressive or Self-Derogatory - does things to hurt self, says negative things about self.

17. Temperamental, Overly Sensitive, Sad, Irritable - moody, easily depressed, unhappy, shows extreme emotions and feelings.

18. Withdrawn - daydreams a great deal, does not mingle freely with other children, gives in, complies without much show of feeling (but may occasionally "blow-up"), not included by other children; doesn't have friends, tends to be an "isolate," out of touch with reality.

19. Anxious - keeps asking, "Is this right?" "Did I do this right?" Wants constant reassurance, has nervous mannerisms, fidgets, bites nails, chews pencils, etc.; seldom satisfied with own performance, tends not to get finished, persistent, tends to over-study; tends to be preoccupied with disaster, accidents, death, disease.

20. Self-Stimulation - persistent behaviors such as flicking fingers in front of eyes, shaking hands or head, rocking, twirling, etc.

21. Attachment to Objects - extreme preoccupation with objects with no regard for their intended use, especially round and spinning objects; marked facility with objects.

22. Non-Responsive Behaviors - lacks eye contact, with persistent tendency to turn away or look past other people, especially when spoken to.

23. Immature Behaviors - prefers younger playmates, frequently cries, crawls around room, exhibits poor coordination.

General Bus Management for the Emotionally Handicapped Students:

1. The student needs support from structure. Routine is very important to the student in that it offers guidelines for their actions and it also provides them with a sense of security. The bus driver should establish a structure that is reasonable and in a format the student can tolerate.

2. Students need to know what is expected of them. Bus rules should be few, simple, enforceable and applicable to all students.

3. Students need to be told when they have followed bus rules.

4. The bus atmosphere should be comfortable and non-threatening.

5. Students should be introduced into the bus situation one at a time if possible. The least severe should be introduced first, since students with less severe problems become integrated into the new environment more quickly than those students with severe behavior problems.

6. It is important to make the new student comfortable in the bus setting. The driver should carefully explain bus rules, procedures, schedules and expectations to the student. The student should be assigned to his/her place in the bus. The assignment of a buddy may also help the new student feel at home.

   a. Planned ignoring - Ignore inappropriate behavior until the student's behavior becomes appropriate. This should always be followed by an approval response as soon as the behavior becomes appropriate.

   b. "Signal interference - signals that communicate to the student a feeling of disapproval and control. These non-verbal techniques include such things as eye contact, hand gestures, tapping or snapping fingers, coughing or clearing one's throat, facial frowns and body postures. Such non-verbal techniques seem to be the most effective at the beginning stages of misbehavior." (Long, 1966, p. 52)

   c. Proximity control - This is especially appropriate for very young students. A student who is having difficulty operates as a source of protection, strength and identification for the student.

   d. Interest boosting - If the student is showing signs of restlessness, it may be helpful if the bus driver shows genuine interest in the student. Mentioning some of the student's pet interests often helps the student to mobilize his/her forces and view the driver as a person to please.

   e. Humor - This can be very helpful in handling behavior problems. Friendly humor can be used to elicit responses incompatible with anxiety and aggression. The use of humor shows the student that the driver is also human and that he/she is secure enough in his/her role to be able to joke.

   f. Hurdle help - Disturbing behavior is not always the result of some inner problem. Sometimes the student is frustrated by the bus assignment. In this situation the student is likely to translate his/her frustrations into inappropriate behavior. The solution is to provide the student with the help he/she needs before the student gets out of hand.

   g. Removing seductive objects - Certain objects have particular appeal and can be distracting for students. The objects should be removed from the bus and put out of sight within the bus.

h. Physical intervention - Sometimes a student acts out in the bus in a way that is harmful to the student and/or to others. In this situation, physical restraint may be the only option open to the driver. This is not intended in any way to be corporal punishment.

In summary the bus driver needs to use common sense when dealing with the emotionally handicapped student. They are children and the driver needs to be warm and loving but firm. They should not over-react but should step back and think before acting. Try to predict what might happen.

There should always be three-way communication taking place in which the driver is the intermediary between the parent and the school. Again be consistent in your approach and remember they are children.

CONDUCTING THE TRAINING SESSION

Persons available to conduct the discussion of the session on the emotionally disturbed student would be the supervisor or lead teacher of the emotionally disturbed program or a school psychologist. It would be helpful to have copies of the Resource Manual for the Development and Evaluation of Special Programs for Exceptional Students Volume II-E available as reference material.

In many instances the school bus driver may not identify a student as emotionally disturbed, especially if the student is remaining in regular classes with a dual placement in a resource class. If good communication has been established with other school personnel, information such as this often is transferred to the driver, along with suggestions for helping the student during the bus ride.

During this session it is often necessary to stress good bus management. In many ways the same techniques are appropriate as those used by the teacher in the classroom. With the emotionally disturbed student, care should be taken to keep the environment calm in order to avoid triggering behavioral outbursts.

COMMUNICATING WITH FAMILIES

For many parents the one person that they see daily and in whose hands they place the life of their child is the school bus driver. That driver becomes their day-to-day link with the school and the relationship and support that develops is of the utmost importance.

In order to assist these drivers in better understanding the importance of their contacts and better ways of communicating with these families, the following component has been developed.

Objectives: To provide the bus drivers of exceptional children with an opportunity to:

-Interact with each other as they become more knowledgeable about themselves.
-Better understand the families of the children they transport.
-Better understand their role as an extension of the school.
-Develop their communication skills and sensitivities to these families.

Any workshop developed should provide an agenda that includes, but is not limited to:

1. An experiential exercise that allows them to talk, in a small group setting (5 to 7 people) about themselves. This experience should include an opportunity for them to talk about some positive experiences they have had as bus drivers of exceptional children and to improve their listening skills. At the close of this experience, time should be allowed for feedback and the processing of feelings generated by the experience.

2. A discussion relating to the parents that makes them more aware of the anxieties parents may demonstrate. This discussion should include:

   -Recognizing the need for positive communication.
   -Becoming more sensitive to verbal and non-verbal communication.
   -Recognizing basic needs that these parents have and examining road blocks to meeting these needs.
   Examples: Acceptance, respect, confidentiality, anxiety, support, etc.

3. A discussion that examines their role as a home-school linkage relaying information about the student from the parent to the teacher. Keeping the teacher abreast of expressed parental anxieties that may affect the child's school involvement.

4. A time to discuss, explore and resolve other concerns they may have.

5. Completion of an evaluation form on this section of the workshop (if not included in a general evaluation).

CONDUCTING THE TRAINING SESSION

The success of this component depends largely on the knowledge and expertise of the leader in reference to communication skills, exceptional students and working with families.

In view of this, it is recommended that a school social worker or visiting teacher be used as a discussion leader. The use of this person also paves the way for continued interaction and follow-up between bus drivers and school social workers or visiting teacher as they seek to meet the needs of exceptional students and their families.

MEDICAL ASPECTS OF TRANSPORTING THE HANDICAPPED

This topic overlaps many of the previous presentations that have been given because there is no way one can discuss handicapping conditions without also discussing some of the medical aspects of the condition. Several major facets pertaining to the medical concerns need to be addressed and stressed therefore.

Primary to our concerns of understanding the medical implications of a handicapping condition is establishing good communication with the parents, with other school personnel and with the student himself. Only in this way can the school bus driver begin to understand how to watch for the warning signs and the possible danger signals exhibited by students being transported.

Parents can be of great assistance because of their exposure to the child's handicapping condition over a period of years. They are also the primary link with the doctor who is in a position to alert persons responsible to possible danger signals.

Communication with other school personnel may give additional information regarding the needs of the students. The school health nurse, the teacher, the occupational therapist, the speech therapist, the physical therapist and others on the school campus can alert the driver to many conditions which, if known, can avoid many unhappy and potentially hazardous situations from arising. Close cooperation between all members of the school staff is a vital part of safe and hazard-free transporting.

Examples of the kinds of information which need to be exchanged can be grouped into several areas. The first is obviously the physical condition of the student. The school bus driver needs to have specific information on a variety of conditions which are the unique characteristics of each student. When are the student's seizures likely to occur? Is the student able to withstand drafts with no ill effects?

The use of orthotic devices is another area which requires the school bus driver to seek information. Braces, wheelchairs, crutches and other appliances which some students use are often necessary to assist mobility or for corrective purposes. It is important for the driver to know when these devices are malfunctioning to avoid possible injury to the child.

Blindness and deafness present yet another set of challenges. A blind student needs to be encouraged to be as self-sufficient as possible. Often we have a tendency to overprotect the blind person which may not be in the best interest of the individual. The deaf student's needs are dependent on his mode of communication and may require that the driver or the aide learn some simple signing so that directions can be clearly understood.

The student with cerebral palsy is often misunderstood and can be the object of ridicule because of his lack of motor coordination and poor speech. Every attempt needs to be made to make these handicapped individuals a part of the group. In most cases, situations which cause a high level of excitement will have the effect of decreasing the degree of control which the cerebral palsied person might have, causing an increase in drooling and body movement and making speech more difficult. The school bus driver should make every effort to keep excitable activities at a minimum when transporting these students. The cerebral palsied often need to be protected from stumbles and falls which could cause bruises and injury.

The Down's Syndrome child is usually good-natured and cooperative but can become confused in unusual situations. Routines should be established and adhered to as closely as possible for this student.

Many other specific conditions exist in handicapped individuals which could be addressed in detail in this manual. However, school bus drivers still have the responsibility of going to the most appropriate person(s) to get the information which will prepare them to transport students as efficiently as possible. The general rule of thumb to be used in all cases is to always be gentle, to be persistent and to be consistent.

CONDUCTING THE TRAINING SESSION

The person best qualified to lead this discussion would be someone from the medical profession. A pediatrician would be an excellent choice but persons in private practice are not usually available. The school nurse or the public health nurse or medical doctor might be more accessible. The staff from Children's Medical Services is also a possible source for competent leaders.

This discussion period will generate other topics such as contagious and infectious diseases and how to control them, child abuse and medical emergencies. The discussion leader should be prepared to discuss these topics briefly if time permits. Future workshop sessions can also be planned to deal with these topics more fully.

LEGAL ISSUES IN TRANSPORTING THE HANDICAPPED

School bus drivers who have the responsibility of transporting handicapped students must face many problems and crises daily which are not common to other drivers. In addition to protecting the safety of each person being transported, drivers of the handicapped must be able to make judicious and appropriate decisions regarding the proper way to handle an emotional outburst or a grand mal seizure. They must also be able to make a determination of when medical attention is required and to have several alternative strategies for handling emergencies.

The variety of situations which could arise requiring careful decision-making on the part of the school bus driver who transports the handicapped are far too numerous to touch on here. It is obvious however that above and beyond driving the bus and loading and unloading the passengers safely and efficiently, drivers of these students must be able to handle not only the most unusual emergencies but also to cope with the usual kinds of trauma which are part of the lives of these students.

School bus drivers have always been aware of the enormous responsibility which they assume when they begin to transport handicapped students. They have expressed concern over their responsibility in the event that a decision of theirs might be challenged by a parent or guardian and legal action initiated. This is a logical and justifiable concern.

This section on legal issues is not intended to deal with individual cases which the drivers have faced or anticipate facing. Rather it is designated to be instructional regarding legal issues and any particular legal problems should be brought to the attention of the lawyer of the driver's choice who can then analyze the facts and give legal counsel.

School bus drivers of these children often find themselves in situations where they may be forced to ask themselves, "Am I doing the right thing?" "Can I be held legally responsible if what I do turns out wrong?" "Under what circumstances would I be considered negligent in carrying out my duties?"

To make these decisions, it is necessary to have a clear understanding about what constitutes negligence. In a brief presentation it is not possible to explore the subject indepth. Basically, however there are four elements of any negligence action. The first one is duty. All of us in carrying out our activities have the duty to conduct ourselves as reasonable and prudent persons. This duty implies that we conduct ourselves so that we don't hurt or injure someone else. The school bus driver must act as a reasonably prudent person in all aspects involved in transporting handicapped students.

This statute gives a certain degree of legal immunity to persons who are employed by the Local Education Agency from a suit and from being held personally liable in tort. Negligence is one form of tort, i.e. civil action between citizens against each other. This statute then says that if you are an employee of the state or its subdivisions, you cannot be held personally liable for injuries or damages suffered as a result of this employment unless it can be proven that the employee, in this case the school bus driver, "acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety or property." Under this statute, further, a driver cannot be held personally liable for simple negligence, i.e. that a breach of duty caused damages. The employer becomes liable for the negligence and his insurance must pay any damages incurred.

The second element of negligence is the breach of that duty. Failing to do something that a reasonably prudent person would have done under the same or similar circumstances would constitute a breach of duty.

The third element of negligence is causation. This means that the school bus driver would have to be the cause of an accident or injury which the student incurs because of a failure to live up to the duty which has been assumed.

The fourth and last element which must be present to determine negligence is damage. As a result of a breach of duty it must be shown that the injury or accident was caused by the school bus driver acting in an irresponsible and imprudent manner and that this resulted in damages to the injured party such as medical expense, etc.

In a negligence suit if it is alleged that a school bus driver was negligent in transporting the children, then the test that a jury will be judging the case on is whether that school bus driver acted in a reasonable and prudent manner as another person would have under the same or similar circumstances. This would be the last step in a determination that a bus driver had acted in a negligent manner.

Consideration should also be given to state legislation which speaks to school bus drivers and their responsibilities. FS 232.23 addresses itself to the Authority of the Principal as follows:

> *Subject to law and to the rules of the state board and the district school board, the principal in charge of the school or his designated representative shall develop policies by which he may delegate to any teacher or other member of the instructional staff or to any bus driver transporting students of the school such responsibility for the control and direction of students as he may consider desirable.*

FS 232.28, Authority of School Bus Drivers:

> *(1) The principal shall designate to the school bus driver such authority as may be necessary for the control of pupils being transported to and from school, or school functions, at public expense.*
>
> *(2) Any pupil who persists in disorderly conduct on a school bus shall be reported to the principal by the driver of the bus and may be suspended by the principal of the school he attends from being transported to and from school, and school functions, at public expense.*
>
> *(3) The school bus driver shall preserve order and good behavior on the part of all pupils being transported but shall not suspend the transportation of or give physical punishment to any pupil, or put any pupil off the bus at other than the regular stop for that pupil, except by order of the parent or the principal in charge of the school the pupil attends; provided, that should an emergency develop due to the conduct of pupils on the bus, the bus driver may take such steps as are reasonably necessary to protect the pupils on his bus.*

In this instance, the school bus driver is charged with the responsibility of doing what is reasonably necessary to protect the student(s) on the bus in the event of an emergency due to the conduct of pupils on the bus. This does not necessarily imply misconduct only, but could be any situation which potentially endangers passengers. In the case of control and direction of a student who is having a grand mal seizure on the way home from school, a reasonably necessary step might be to pull off to the side of the road, make the student comfortable and clear of danger and instruct other students concerning their actions. In another situation, seeking of medical aid as quickly as possible might be the reasonably prudent action. It is important to stress that although school bus drivers do receive training in first aid, they are not qualified or certified to administer medical assistance beyond what this training allows.

The standard of care against which bus drivers are measured is based on that of a person with a first aid certificate and what is reasonably prudent with this training, not on what a licensed medical doctor might do in the same or similar circumstance. In other words, the statutes do require that action be taken in certain situations, but only insofar as the training the driver has received would logically allow this.

In Florida we are fortunate to have statutes which protect school bus drivers and other government employees against liability.

FS 768.28 states:

> *No officer, employee, or agent of the state or its subdivisions shall be held personally liable in tort of any injuries or damages suffered as a result of his employment or function, unless such officer, employee, or agent acted in bad faith or with malicicus purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.*

CONDUCTING THE TRAINING SESSION

For this topic, Legal Issues of Transporting the Handicapped, the discussion period should be led by a member of the legal profession, a lawyer, member of legal aid society or a person knowledgeable about school law and responsible for providing pre-service or in-service instruction on the topic. In many communities the school board attorney may be the most accessible and knowledgeable person available.

The discussion period should be general so that there is no intimation that legal advice concerning specific cases is available. Sharing of experiences is an valuable part of every session. In this case, however, training should emphasize the legal responsibilities of the individual driver rather than involving a gamut of related but not necessary relevant responsibilities.

HANDLING SEIZURES

Epilepsy is the Greek word for "seizure." The seizures are not always accompanied by convulsive movements, but they do involve a temporary interruption of consciousness.

Epileptic seizures are caused by a disturbance of brain function, an "irritation" of the brain - a sudden, violent disorderly discharge of electrical impulses from the brain cells. Sometimes an injury to the brain will set up the disorder.

There are a number of factors that occur during a person's birth or lifetime that could cause damage to the brain and result in seizures:

1. German measles in the mother during pregnancy
2. Various infections in the mother during pregnancy
3. Rh blood incompatibility
4. Toxemia of pregnancy
5. Abdominal injury to the mother during pregnancy
6. Premature labor
7. Difficult labor or complicated labor
8. High fever within the individual
9. Head injury
10. Viral encephalitis (infection of the brain)
11. Congenital brain defects (Hydrocephalus)
12. Various metabolic errors (low blood sugar, low blood calcium),
13. Vascular sclerosis
14. Severe kidney diseases (uremia)

Note: All seizures are not indicative of epilepsy. Toxic agents and high temperatures may also result in convulsions. In rare instances, convulsions may be associated with a major heart problem.

There are four types of epileptic seizures:

1. Grand Mal
2. Petit Mal
3. Psychomotor
4. Jacksonian

Grand Mal seizures (generalized convulsions) take the form of black-outs and violent shaking of the entire body. They may be accompanied by irregular breathing, drooling, or a pale blue color in the face, fingernails or lips. Some patients experience a warning, called "aura," before a seizure, such as an unexplained feeling of fear, unpleasant odors, peculiar sounds, tingling of skin or spots before the eyes. After the seizure, the patient may feel confused or tired, and may fall asleep.

Grand Mal seizures usually last a few minutes. After the seizure the student may be sleepy, confused, exhausted, and complain of headache. The student may have no memory of the seizure; however, it is not uncommon for the student to resume normal activities after having a brief grand mal seizure.

Petit Mal (absence) seizures occur most often between the ages of 6 and 14. They may appear to be staring spells. They are sometimes mistaken for daydreaming and may result in behavior or learning problems. Other signs of petit mal seizures may be rapid blinking of the eyes and/or small twitching movements. This type of seizure may occur as frequently as 100 times a day, and most often lasts less than a minute. After the seizure, the patient usually goes back to what he was doing before it occurred, as if nothing had happened.

Infantile myoclonic and Akinetic Convulsions affect either consciousness or muscle control and movement, and are seldom controlled by medication. They have been nicknamed "lightning seizures" because they may occur from 5 to 300 times a day. This type of seizure should be suspected in the "lazy" infant, or 6 to 18-month-old child with crying, colic, poor eating habits, staring, muscle jerks or twitching and slow motor development. The infant may suddenly draw his body into a ball, or have his arms and legs jerk into the air. His face may be pale, or red or even a blue color. Following a convulsion he may seem to have lost all energy or interest in his surroundings. In older children or adults, these seizures may cause a sudden falling to the ground, resulting in frequent bumps and bruises.

Psychomotor seizures arise from a specific area in the brain and may occur at any age. They take a variety of forms, including chewing and lipsmacking, staring, headaches and stomach aches, color changes, spots before the eyes, buzzing or ringing in the ears, dizziness, or strong emotions such as fear or rage. Sometimes the patient cannot remember what has happened during the attack. Purposeless movements are common, such as night or day walking, picking at or taking off clothes, and rubbing hands or legs. These movements are call automatism.

Psychomotor seizures are usually about one minute in length, and the student may be confused for another minute after the seizure. This type of seizure occurs more often in adults than in children.

Focal Motor seizures originate in the area of the brain which controls muscle movement. When nerve cells in this area produce a sudden electrical discharge, various parts of the body may jerk, or show other forms of movement, in an orderly manner. The individual is conscious throughout a motor seizure and is left only with some muscle weakness in the areas affected.

Autonomic seizures consist of repeatedly occuring symptoms of headache, stomach ache, nausea, vomiting or fever which may contribute to periodic behavioral, learning and emotional problems. These are a type of partial seizure (beginning locally) during which the patient does not lose consciousness.

Autonomic seizures are sometimes referred to as the "convulsive equivalent." The symptoms are most common in children, particularly when there is a family history of headaches or seizures.

It is possible for an epilepsy patient to have more than one type of seizure. This is one reason why careful diagnosis and individual treatment by a competent physician is so important.

Action to be Taken by Bus Driver

1. Keep calm
2. Do not leave the student alone during the attack
3. Do not restrain the student or interfere with his movements
4. Clear the area around him so that he does not injure himself
5. Do not force anything between his teeth
6. Loosen clothing around student's neck and waist
7. Turn head to one side allowing saliva to flow from his/her mouth
8. Place something soft under the student's head (pillow, folded blanket)
9. If the seizure is 10 minutes in length, or if the attack is followed immediately by another seizure, call a doctor
10. After the seizure is over, let the student rest if he/she desires

Medications Used in the Treatment of Epileptic Seizures and Their Side Effects

Dilantin - Uses: Grand Mal
Side Effects: Drowsiness, nausea, skin rash, vomiting

Phenobarbital - Uses: All types of Seizures
Side Effects: (rare) possible skin eruptions, dizziness, nausea, diarrhea, staggered gait

Mysoline - Uses: Psychomotor, Jacksonian, Grand Mal
Side Effects: Drowsiness, staggered gait

Tridione - Uses: Petit Mal and Other Epilepsy
Side Effects: Rash, visual disturbances, sore throat, abnormal blood condition

Cremonil - Uses: Grand Mal, Petit Mal, mixes types of seizures
Side Effects: Ataxia, tremors, dizziness, rash

CONDUCTING THE TRAINING SESSION

It is recommended that the film Images of Epilepsy (12 min.) be used at this session in place of a taped presentation. The film depicts the three types of seizures and gives recommendations for intervention. The local chapter of the Epilepsy Foundation has the film available for loan.

A representative from the Epilepsy Foundation would be an excellent choice to lead the discussion. Pamphlets and brochures are also available from the local chapter.

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LIFTING, CARRYING AND TRANSFERRING

Children who are unable to stand or walk require the assistance of an adult for changing their position. When techniques of lifting, carrying and transferring handicapped children are correctly executed, stress and possible injury to the child and adult are avoided. Depending on the type of procedure and the abilities of the child, he may be able to assist with the mobility skill if he is given the opportunity during the process.

Some general guidelines for lifting, carrying and transferring are offered below. Prior to performing these procedures, it is recommended that the bus driver and bus driver aide participate in the workshop session where a physical therapist demonstrates the correct technique and the participants practice each procedure.

Recommendations for lifting, carrying and transferring the physically impaired student are included as a general guide for school bus drivers and driver aides who may be required to provide this service in an emergency. It is recognized that SBER 6A-3.121(4)(b) and SBER 6A-3.121(5)(b) specifically delineate the circumstances under which the school bus driver can render assistance. The intent of this section is to give school bus drivers the benefit of knowing appropriate methods, not to imply that lifting, carrying and transferring is assumed to be the responsibility of the driver.

General Guidelines for Lifting, Carrying and Transferring

1. Never attempt to lift, carry or transfer a child who is too heavy or too difficult to manage alone. If two people cannot manage the procedure, a mechanical lifter may be required. This should be carefully selected and operated only by a person familiar with its use.

2. Prior to lifting, the specific movements should be planned. If another person is assisting, they should discuss the procedure to coordinate their movements.

3. The chair, bed or other surface should be properly positioned to facilitate the procedure. If a wheelchair is involved, the brakes must be applied and the footrests must be lifted or removed.

4. Quick movements of the child must be avoided. This may cause fear in the child and spastic muscles will become more tense.

5. The child should be told what is to occur and how he can assist in the process.

6. Proper body mechanics should be followed, e.g., bend at the knees, not at the waist, get as close to the child as possible; keep the back straight; avoid lifting higher than the waist; do not lift quickly.

LIFTING

The general principles of lifting, lowering, carrying, and transferring apply whether one is lifting a wheelchair into a school bus or transferring a non-weightbearing child into another conveyance.

Step-by-step procedures in all situations are as follows:

1. Understand that general principles are always the same, but the easiest method varies with the capabilities of the helper, as well as those of the student.

2. Find out how much the individual is accustomed to doing for himself.

3. Determine how much he can cooperate in the proposed change of position.

4. Have him take part in each change of position as much as possible.

5. Assist him to move with as little lifting, carrying, or lowering on your part as possible; use a mechanical aid whenever possible.

Principles of Good Lifting

1. First, plan the job.

2. Be sure that there is ample room for good footing and that the path is cleared for the carry or transfer.

3. Stand so you will not have to twist your body as you lift the patient.

4. Guide the child as he moves to the step below him. Let him steady himself on each step.

5. Move to the next lower step and repeat the actions listed above.

Falling While Carrying

1. If close to a wall or other stable object, rest weight on it.

2. Be alert to protect the child's head.

3. Fall under or to the side of child.

4. Turn child away from hard objects.

5. Fall against the bed or other soft object if close.

6. If falling downstairs, try to lower to sitting position on step.

7. If falling upstairs, turn and sit on the stairs, holding into the child.

8. After stumbling, crouch and sit down to prevent tumbling.

Lifting Heavy Child Without Braces from Floor to Standing Position

1. Kneel close behind the child and grasp him under his armpits, with the grasp pressure against the trunk.

2. Raise the child to a sitting position.

3. Shift to a stride position with your knees bent and back straight.

4. Still grasping child under armpits, raise him to a standing position by straightening your legs and shifting your weight quickly toward your rear foot.

Assisting Child to Walk During Change of Position

If the child is able to support his weight on his legs and is able to take steps but has difficulty in maintaining his balance, assist him as follows:

1. Stand close behind him so that your forward leg is in contact with the child.

2. Grasp his waist or the waistband of his brace with one hand. Place your other hand over his shoulder or under his armpit.

3. As the child moves forward, keep your hand or leg in contact with him.

4. Use your leg to assist the child in moving forward by swinging the leg forward against his buttock in a lifting motion.

Assisting Child who has Lost his Balance

If the child starts to fall while walking, step close to him and place your leg next to him for support or to break his fall. If at all possible, grasp his clothing or trunk, and as his body is lowered, shift your weight away from the direction of his fall and draw him against your supporting leg.

If the child is falling toward you, crouch and place one leg under him or place your thigh against him while supporting his upper trunk with your hands.

Caution

The goal should be to prevent injury, not to regain balance. Do not reach outward or lean over to catch him.

Assisting Child to Walk Downstairs

1. At the top of the stairs, place the child's hand or both hands on the rail, and while steadying him, move to the step below him and face him.

2. Grasp the child's waist and move to the next lower step. Stay close to the railing. Keep your weight forward. Rest your arm and hip against the rail.

Additional Considerations

If the wheelchair's drive wheels are forward, turn the chair so that the handles are toward the school bus and the drive wheels are against the side of the bus. Enter the bus and, with the legs in a stride position, crouch and grasp the handles of the wheelchair. Draw the wheelchair into the bus by shifting the weight to the rear.

Removing the Wheelchair from School Bus

1. Align rear of wheelchair with door and move it close to the edge of the school bus.

2. From outside the bus, stand with the legs in a stride position.

3. Grasp the handles and tilt the chair backward.

4. Draw the chair to the edge of the bus by shifting the weight to the rear leg. Roll the chair on its large wheels.

5. Crouch and control the descent of the chair by forcing the wheels against the edge of the bus as the chair is lowered.

CARRYING

Principles of Good Carrying

1. Avoid carrying whenever possible by using a household chair with wheels added, tricycles, wheelchairs, or hydraulic lifts.

2. When carrying is absolutely necessary, hold the load as close to your chest as possible.

3. Keep a firm grasp. If your grasp becomes loose, rest the child against something while you secure a firmer grasp.

4. Keep your back straight, not arched-either forward or backward.

5. Do not twist; turn your whole body.

Carrying a Child Without Tight Adductors

1. Keep your arms close to your body.

2. Rest part of child's weight on your hips and counterbalance his weight by leaning back from slightly flexed knees, without hypertension of lumbar spine.

3. Have child lean against you, since he cannot help by holding your shoulders.

Carrying a Child Horizontally, if Necessary

1. Hold the child with one of your arms under his knees and the other under his chest, your palms facing upward.

2. Hold the child tightly against your body to relieve arm strain and prevent shifting.

3. Take short steps to maintain balance; do not walk fast.

4. Keep your hips under the load of your upper body and the child.

5. Walk with a large share of the weight over your heels.

6. In carrying a heavy child for short distances, support his weight against your upper thighs. Keep your hips slightly flexed.

Lifting Child from Wheelchair to Standing Position

1. Apply wheelchair brakes. Face the child.

2. Crouch to swing footrests into vertical position, out of the way of the child's feet.

3. Stand in a bent knee position with forward leg between the child's knees and place your hands about the child chest or under his armpits.

4. Shift your weight backward over the rear foot as you slide the child to the front of the seat.

5. Have the child lean forward and keep his weight over his feet as you draw him up to a standing position. It may help if he holds your hips or shoulders.

4. Stand close to the load, with one foot ahead of the other; the foot that is ahead should usually be in the direction you are going (Fig. 1-2).

5. Do not try to lift from a kneeling position, as this takes away the power source. However, with smaller children or loads, it may be advantageous to start to lift with one knee on the floor.

6. Get a good grasp before starting to lift.

7. Make a preliminary lift to see if the student weight is within your capacity.

8. If the weight of the load is more than one-fourth of your body weight or if it is awkward, you should get someone to help you.

9. Lift one end of the load slightly, if necessary, so you can place one hand underneath it in order to get a firm grasp.

10. Get your legs ready for the lift by bending them. Do not attempt to lift a load with your legs bent beyond the right-angle position.

11. Lower your body near the level of the object to be lifted.

12. Be sure your back is straight. If it is neither rounded nor arched, and is as near the vertical position as possible, you will avoid strain.

13. Be sure your shoulders are directly over your knees and your hands reach straight downward to the load.

14. To be in the proper position, let your back muscles hold your back steady as your leg muscles tense to go to work.

15. Lift by straightening your legs in a steady upward thrust, and at the same time move your back to a vertical position.

16. Keep the weight of the load close to your body and over your feet.

17. As your legs straighten, keep your back straight.

18. To change direction during a lift, step around and turn your whole body, without twisting at the waist or lower back.

CONDUCTING THE TRAINING SESSION

A physical therapist would provide the optimal input as a discussion leader for this session. An occupational therapist could also provide much information. Classroom teachers who have worked with physical and occupational therapists should also be considered for leading the discussion period.

If possible, this training period should involve handicapped students. Then techniques can be demonstrated and braces, wheelchairs and other orthotic equipment examined. Making a school bus available for demonstration purposes, both with and without a hydraulic lift, is also beneficial.

In all cases, samples of as many orthotic devices as possible should be made available during this session. Orthotists in the area will often agree to attend the session and will bring demonstration models with them.

GENERAL CONSIDERATIONS

There are many matters which a driver should discuss with the school staff. The proper way for these discussions to be handled is always to begin with the person in charge of transportation at the school or with the dispatcher who is the bus supervisor. If, after talking it over, the matter needs further discussion, an appointment should be arranged so the driver can speak with a teacher, nurse, social worker, school psychologist, or another staff member. Drivers should not barge into any school building to handle problems directly, since that would interfere with the school day. The school staff is very much concerned about the bus driver's problems and will do everything possible to help solve them. The cooperation of the drivers is essential in following the above defined routine in order to handle problems properly. Some matters a driver might wish to discuss are the following:

1. Child not ready when bus arrives. If the driver is sure that arrival is at the same time each day and there is an undue delay constantly with one child, he should talk with the parents. Such talks are best held at some time other than the morning pick-up time, since both parties might be quite annoyed at that time. An explanation given pleasantly that the delay at the one home is delaying all the other children and resulting in late arrival at school for the group will more than likely result in cooperation from the parent. If this talk doesn's solve the problem, then talk it over with the dispatcher and the school staff for further handling. (SBER 6A-3.121(3), and SBER 6A-3.121(5)(a)

2. Child has toileting accidents. This will happen occasionally, especially when the regular time schedule is not operating. If the bus is late, ask the parent to notify the rest of the parents of your estimate of the delay so they can toilet their children accordingly. If this is a constant problem, the driver should notify the transportation supervisor at the school. A conference of the school staff might bring about a simple remedy for the problem.

3. Child misbehaves on the bus. Often a change in seating partners will cure misbehavior. As mentioned earlier, a meaningful routine in which all the children take part is a necessity for good order. The driver or aide might try to vary the routine being used so as to attract the interest of the child who is misbehaving. Such problems are seldom cured by raising the voice and becoming upset. If necessary, the sub should be stopped in a safe place and have the youngster sit behind the driver. Upon arrival at the school, the driver or aide should notify the school staff of the

incident and the dispatcher should be informed. A written report is good practice. As a last resort, changing such a child to a different bus can solve the problem. Should physical force be needed as the only way to solve a problem, make sure the bus is safely stopped and then only use the force necessary to contain the child without hurting him. Instances are rare where children require any kind of force.

4. Child sleeps on the bus and falls over. Be sure such a child is securely buckled in his seat belt. Seat him in such a way that he is supported on one side of the bus and on another by a helpful child. The sleeping should be mentioned to the parent and to the school staff. Many of these children receive medication and sometimes, due to physical changes, the medication brings results other than what was intended. In such a case, the school nurse can often bring about a change by notifying the parents.

5. Child has epileptic seizures. During an attack, the child loses consciousness, his muscles tighten, and he falls. He may cry out or groan, although he is not in pain. Saliva appears on his lips. His face may first be dusky and then pale. He might twitch violently for a minute or so - it may seem longer to the worried bystander. Usually in a few minutes he lies relaxed. Then he may fall into a deep sleep. When, and if, one of the children on your bus has a seizure, the most important thing to do is to remain calm. Get your bus to the side of the road and stop safely. Try to keep him from injuring himself by banging into the seats with his arm or head. Turn his head to one side for release of saliva. Place a cushion or a folded coat under the head. Loosen garments around the middle of the body. When the twitching is over, continue your trip and report the seizure to the parent or the school staff depending on your destination. Keep the following facts in mind: despite what it may seem, when a child has a seizure, he does not suffer any pain. A seizure is not as harmful as it may appear. It is usually harmless and will be over in a few minutes. The observer is never harmed.

6. No one is at home in the afternoon when the bus get there. This is a very serious matter since all personnel, aside from personal concern for the children, are charged by law with the responsibility of taking every step a reasonable person would take to ensure the safety of the children. If there is not a responsible person at home, keep the child in the bus, finish the route, then go to the nearest phone, taking the child along, and contact the school administrator who will in turn contact the appropriate authorities and relieve the driver of his responsibilities. (SBER 6A-3.121(3)

While the few situations outlined above do not exhaust the many one may deal with, they occur most often. If other matters arise, discuss them with the immediate supervisor. Everyone working with children being transported is interested in contented drivers. To that end, this material is closed with a short list of do's and don'ts which the experience of many drivers has proven to be of value.

1. DO remember that nothing starts the day off better than a big smile, a cheerful "hello", and the sound of one's own name spoken cheerfully.

2. DON'T try to bribe the children into good behavior by making false promises or idle threats, or by offering candy, snacks, or other material things as a reward for behaving properly. Work out a routine that will both benefit the child and keep him occupied, thus curbing bad behavior.

3. DO stay with the bus at all times when it is occupied by even one child. Aside from the fact that is the law, protection of children from one another and from harming themselves demands it. If an emergency arises, and you need help, flag down a passing car or attract the attention of nearby people by blowing the bus horn. People are usually attracted to school buses in difficulty and are willing to offer help. Once having contacted help for the emergency, continue on the route, but if a driver must wait due to a flat tire or breakdown, then he should make provision beforehand for some way to occupy the children in a pleasant way. Perhaps a transistor radio could be kept available for such a time, a children's storybook or a book of simple poems, a songfest or a game of simple charades which can be performed while seated, or any device that suits the group aboard the bus. If the driver does not have a plan to handle delays, he will find the children inventing their own activity, like crying loudly, pulling hair, handwrestling, hornblowing, etc. If a driver must leave the bus, all the children should go with him, pairing them with the less handicapped guiding the more handicapped.

4. DO try to develop the cooperation of all the parents of the children who ride the bus. One very useful arrangement is the formation of a telephone chain. If each parent knows the telephone number of the nearest child to his home, then in the event the bus is delayed at any time, one telephone call from the driver would have all the parents on the route notified in a matter of minutes. This arrangement would be a big help especially in the afternoon when, if the bus is delayed for any length of time, parents worry about their youngsters' safety. Moreover, the driver would be helping parents to become acquainted with one another, and in case of a family newly moved into the area, the driver might be providing them with their first friends in a new neighborhood.

5. DON'T make changes in your route without discussing them with your dispatcher and staff. Should you be absent, a substitute driver would have a big problem getting everyone to school on time.

6. DON'T drop a child off at a place other than his own home unless you clear the matter with the dispatcher, the principal, and the parents.

7. DON'T transport anyone other than those your dispatcher has instructed you to pick up. Again, important laws are involved including the invasion of the privacy of children.

8. DO try to keep your personal problems to yourself. The parents have enough of their own without having the additional worry of an upset driver at the wheel of their child's bus.

9. DO have the good sense not to argue with parents. If there is a disagreement, one side is making a mistake in some way. Speak to the principal and the dispatcher who can resolve the problem. If the parent is mistaken, a school person or the dispatcher should discuss the problem with the parent.

10. DO make visits within the school buildings very brief and inconspicuous. With these children, the sight of a bus driver means it is time for the bus trip home and the school day ends the minute they see him. At dismissal time, stay with the vehicle. The school staff has the responsibility of bringing lagging children to the bus.

11. DON'T move your bus when retarded children are nearby. In many cases, the children are not capable of making judgements regarding their safety. Move the bus only on direction of the school staff. The great safety rule on school property is a very simple one: WHEN CHILDREN WALK, BUSES STAND STILL.

12. DO try to understand some of the problems of these children when they misbehave. Many times they will seem to ignore the driver's instructions. At such times maybe the child did not hear or did not understand what was said. If he is a slowpoke, try to understand that his motor just doesn't go any faster. If you are offended at the odor given off by a few, understand that it is not because the child is unclean but that his body chemistry works differently from the rest of us. If he denies doing something that happened before your eyes, don't call him a liar. He may not remember doing it or if he does, he may not understand that that's the act you are discussing.

13. DO keep a list of emergency telephone numbers on the bus.

The aim of this manual is to help drivers of buses with handicapped children to prevent problems, to solve others, and to explain, in a small way, those problems that cannot be solved, at least with the knowledge we have now.

SUMMARY

If you know the actions and reactions of a normal child, you are ready to understand the abnormal reactions of the handicapped students.

Accident and Emergency

Some passengers may require special treatment in case of accident because of their disability. The physically handicapped, the mentally retarded and the emotionally disturbed are examples of students who may need special help.

a. A small sign placed near the door handle, easily visible may list "Occupants need special medical attention in case of accident or emergency."

b. For the driver's own use, you should have a small notebook containing each passenger's name, address, telephone number, doctor's name, primary disability, kinds of medication and other information necessary to assure safe treatment in an emergency. The school bus driver is not to administer medication, however. (SBER 6A-3.121(4)(c)

Discipline

At no time should a driver be faced with a potentially dangerous situation. When unusual actions happen, they should be reported in detail to the principal. They could have medical implications. Bus rules, limits, assigned seats, tone of voice and passenger reaction time should be handled according to the individual handicaps. The driver should know about the needs and disabilities of the passengers; the best way to learn these is through communication with parents and teachers. Drivers, teachers and parents should keep an open line of communication so that behavior can be controlled from bus to classroom and back to bus.

Handling

The driver of handicapped children is a very special person. The driver must have stamina, common sense and the ability to accept the handicapped child.

There are safe and effective ways to easily lift a child. The driver should be well informed on how to operate the lift or special equipment which will insure the safety of the child as well as the driver.

Training sessions in the proper handling of exceptional students may be conducted by the Exceptional Student Education Department during pre-school planning.

Good common sense is the magic word. Remember to be firm ---BUT GENTLE, be patient --- BUT PERSISTENT. Always be CONSISTENT.

I. Mental Retardation

A. Educable Mentally Retarded

Definition

One who is mildly impaired in intellectual and adaptive behavior and whose development reflects a reduced rate of learning.

Characteristics

1. Short attention span or lack of concentration.
2. Low frustration tolerance.
3. Difficulty in recalling auditory and visual stimuli.
4. Difficulty in generalization skills and ability to transfer learning.
5. Poor language development.

B. Trainable Mentally Retarded

Definition

One who is moderately or severely impaired in intellectual and adaptive behavior and whose development reflects a reduced rate of learning.

Characteristics

1. Need for developing self-help skills such as buttoning shirts, coats, fastening zippers, tying shoe laces, etc.
2. Limited ability to understand and use language.
3. Short attention span or lack of concentration.
4. Low frustration tolerance.
5. Poor socialization skills.

II. Physically Handicapped

Definition

One who has a crippling condition or other health impairment which requires an adaptation to the student's school environment or curriculum. A child may be handicapped by cerebral palsy, polio, muscular dystrophy, heart condition, etc. (Pregnant students may be classified as physically handicapped).

Dealing with these children in terms of transportation.

1. Be open minded - take suggestions from parents, teacher, or physical therapist regarding ways of moving a severely handicapped child.

2. Be aware of the lifting problems in cases such as muscular dystrophy. This child has a tendency to slip through ones arms.

3. Transport the child to and from the bus in a wheelchair if the child is not able to walk.

4. Encourage independence in the child. Have the child do as much independently as possible.

5. Report to the parent or teacher any accident (bump or fall) the child got during transportation. Vomiting or nausea may occur afterwards. Little things are very important in helping the physically handicapped.

The Epileptic Child

Description

There are many types of epilepsy. Most types are experienced because of birth or delayed damage to the brain, such as any type of accident or an infectious condition such as encephalitis. Tumors or brain hemorrhage are also known causes. There are many epileptics where there is no known cause. Some symptoms of epilepsy are sudden and repeated attacks of dizziness, with severe abdominal pain, but consciousness usually is lost or impaired. Only a qualified physician can diagnose the presence of epilepsy.

There are many different drugs used to manage the epileptic; sometimes a child is on as many as 2 to 6 kinds of medication at a time.

Definition

Grand Mal -- During a Grand Mal seizure an individual loses consciousness, falls down and thrashs around, may bite the tongue and may lose control of bladder or bowels. The child feels no pain and rarely is in serious danger. A PERSON IN A CONVULSION CAN NOT SWALLOW THE TONGUE and will not choke to death if -- when the jerking stops -- the face is turned to the side, so the tongue can drop into the cheek and the saliva can run from the mouth. The epileptic will give the appearance of choking on the tongue while actually drowning in saliva.

Because the Grand Mal attacks are extremely dramatic, they generally are associated with epilepsy by the public. However there are many other less dramatic manifestations of the disorder.

Petit Mal -- During a Petit Mal attack a child may stare blankly, stumble momentarily, drop an object, or act unconsciously for a few seconds. These seizures may occur many times a day. If you note a child acting in such a manner, don't brush it off as a "clumsy child" but keep an eye open to see if this is a pattern. You as a bus driver, should report this to the parent or to the school nurse.

Psychomotor - During psychomotor attacks a child's behavior is inappropriate to the circumstances. While riding a school bus a child's eyes might blink open and shut excessively for a few minutes. The child may stop conversing and just sit smacking the lips or get up and perform purposeless motions. This behavior rarely involves violence. A child does not remember what happens during a psychomotor seizure.

Dealing with these children in terms of transportation.

1. Stop your school bus in a safe place, not in the lane of traffic. Keep other children quiet and in their seats. Remove dangerous objects from the child's surroundings.

2. After the seizure is over, the child may fall into a deep sleep. The bus aide should stay with the child until the destination is reached.

3. Have a list of seizure prone children who ride your school bus. Include information such as type of seizure, frequency, characteristics and precautions. If a child has a seizure while on the bus, inform the teacher or parent as soon as possible.

4. Follow appropriate procedures above.

III. Emotionally Disturbed

Definition

One who exhibits consistent and persistent signs of behavior such as withdrawal, distractibility, hyperactivity or hypersensitivity.

Characteristics

1. Short attention span

2. Restlessness

3. Does not complete tasks

4. Listening difficulties

5. Avoids participation with other children or knows how to play only by hurting others

6. Avoids adults

7. Resistent to direction

8. Unusual language content - strange, fearful, fantasy

9. Speech problems - primarily rate of speech

10. Aggression toward objects and groups

Dealing with these children in terms of transportation.

1. Maintain a set of clear cut rules. The child wants to know the limits he stands at all times. Any deviation from these rules will only confuse the child and may cause "acting out" behavior.

2. Be firm but fair, smile often but be firm and to the point when you correct this child. You are the first key to the pupil's whole school day. You are the first school authority to see the child in the evening. Say "good morning" and show your pleasure to have the child ride the bus. (This is difficult at times but it will pay off in the long run). If a child is on medication - you need to know the effects and if the medication will hold through the bus ride.

IV. Visually Impaired

Definition

Blind: One who after best possible correction has no vision or has little potential for using vision as a primary channel for learning, and therefore, has to rely upon tactual and auditory senses to obtain information.

Partially Sighted: One whose vision, after the best possible correction, although impaired, is yet the primary channel of learning and with considerable adjustments, is able to perform tasks required in the usual school situation.

Characteristics

1. Eyes appear to wander when child tries to focus.

2. Pupils of eyes are different size.

3. Drooping eyelids.

4. Squinting, blinking.

Dealing with these children in terms of transportation.

1. The bus driver may find that the child with sight problems is the easiest of the Exceptional Children with whom to deal.

2. One of the main things to remember is never leave this child alone.

3. Let the child be as independent as feasible when getting on and off the bus.

V. Hearing Impaired

Definition

Deaf: One who is born with or acquires, prelingually, a hearing loss so severe that he cannot learn speech and language through normal channels.

Hard of Hearing: One who is born with or acquires a hearing loss which may range from mild to severe unaided and whose speech and language, through imperfect are learned through normal channels.

Characteristics

1. Have speech problems or obvious difficulty in communication.

2. Highly demonstrative and expressive.

Dealing with these children in terms of transportation.

1. Be gentle though firm and consistent in your rules; this child understands more than sometimes given credit.

2. Ask the teacher if the child has learned to speak; if so, make the child talk with asking for something. (Sometimes this child will pretend to have no speech).

3. Be sure the child is looking at you when you are speaking because some of these children can read your lips.

APPENDIX

FLORIDA DEPARTMENT OF EDUCATION
DIVISION OF PUBLIC SCHOOLS
BUREAU OF EDUCATION FOR EXCEPTIONAL STUDENTS

TRAINING SESSION
SCHOOL BUS DRIVERS
TENTATIVE AGENDA

Day 1

"Lifeline to Learning" - Discussion Film

Introduction - Video or audio tape

Topic 1 - The Student Who is Physically Impaired with Taped Introduction

Topic 2 - The Student Who is Visually Impaired with Taped Introduction

Topic 3 - The Student Who is Hearing Impaired with Taped Introduction

Topic 4 - The Student Who is Mentally Retarded with Taped Introduction

Topic 5 - The Student Who is Emotionally Disturbed with Taped Introduction

Topic 6 - Communicating With Families

Day 2

"Problems in Transporting the Handicapped" - Discussion Film

Topic 7 - An Overview of Medical Aspects of Students Who Are Handicapped

Topic 8 - An Overview of Legal Issues of School Bus Drivers with taped Introduction

Topic 9 - Handling Seizures with "Images of Epilepsy" - Discussion Film

Topic 10- Lifting, Carrying and Transferring the Handicapped Student with taped Introduction

FLORIDA DEPARTMENT OF EDUCATION
DIVISION OF PUBLIC SCHOOLS
BUREAU OF EDUCATION FOR EXCEPTIONAL STUDENTS

School Bus Driver Training Session
Pre-Test

Please write a short definition of the words listed below. Be as specific as possible. (You are not expected to know all of them!)

1. Seizure: _____

_____

2. Discipline: _____

_____

3. Communications: _____

_____

4. Personalized Transportation: _____

_____

5. Physically Impaired: _____

_____

6. Down's Syndrome: _____

_____

7. Mental Retardation: _____

_____

8. Emotionally Disturbed: _____

_____

9. Negligence: _____

_____

10. Positioning: _____

_____

11. Positive Reinforcement: _____

_____

12. Cerebral Palsy: _____

_____

FLORIDA DEPARTMENT OF EDUCATION
DIVISION OF PUBLIC SCHOOLS
BUREAU OF EDUCATION FOR EXCEPTIONAL STUDENTS

School Bus Driver Training Session
Post-Test

Please write a short definition of the words listed below. Be as specific as possible. (Compare your answers with your pre-test.)

1. Seizure: _____

_____

2. Discipline: _____

_____

3. Communications: _____

_____

4. Personalized Transportation: _____

_____

5. Physically Impaired: _____

_____

6. Down's Syndrome: _____

_____

7. Mental Retardation: _____

_____

8. Emotionally Disturbed: _____

_____

9. Negligence: _____

_____

10. Positioning: _____

_____

11. Positive Reinforcement: _____

_____

12. Cerebral Palsy: _____

_____

FLORIDA DEPARTMENT OF EDUCATION
DIVISION OF PUBLIC SCHOOLS
BUREAU OF EDUCATION FOR EXCEPTIONAL STUDENTS

School Bus Driver Training Session
Evaluation

Please circle the Topics below as indicated. This will be helpful to us in planning future training for you.

Circle four Topics which you feel were most useful and informative:

Topic	Title
Topic 1	The Student Who is Physically Impaired
Topic 2	The Student Who is Visually Impaired
Topic 3	The Student Who is Hearing Impaired
Topic 4	The Student Who is Mentally Retarded
Topic 5	The Student Who is Emotionally Disturbed
Topic 6	Communicating With Families
Topic 7	An Overview of Medical Aspects of Students Who Are Handicapped
Topic 8	An Overview of Legal Issues of School Bus Drivers
Topic 9	Handling Seizures
Topic 10	Lifting, Carrying and Transferring the Handicapped Student

Circle four Topics which you feel were moderately useful and informative:

Topic	Title
Topic 1	The Student Who is Physically Impaired
Topic 2	The Student Who is Visually Impaired
Topic 3	The Student Who is Hearing Impaired
Topic 4	The Student Who is Mentally Retarded
Topic 5	The Student Who is Emotionally Disturbed
Topic 6	Communicating With Families
Topic 7	An Overview of Medical Aspects of Students Who Are Handicapped
Topic 8	An Overview of Legal Issues of School Bus Drivers
Topic 9	Handling Seizures
Topic 10	Lifting, Carrying and Transferring the Handicapped Student

The two Topics which are not circled are assumed to be least useful and informative. However, we would appreciate your comments on why you made the choices you did. Thank you for your assistance.

Comments

THE ONE ROOM SCHOOL BUS

WRITTEN BY
LADY BORTON

When people ask what I do, I reply that I teach retarded children and adults ... on a school bus. Four hours each day I wind through the countryside of Appalachian Ohio, stopping for riders at small farms and at old mining settlements. When I first took the job, I expected those hours to be a quiet time in my day when I could think and reflect. But the first day's return trip dispelled that illusion. In the morning the students had boarded sleepily one by one. But that afternoon they piled on, carrying with them noisy excitement from the first day at school.

As we pulled away from school, Fran, Jack, and Sonny bolted up the aisle. In their wake Jennifer and Charlene, who neither walk nor talk, dangled helplessly over the floor, suspended by their seat belts. Johnny sought refuge under his seat from Fran, who is half his size. "Judy is a baby, Judy is a baby." Barbie taunted in a singsong voice. Judy howled, Charles sat quietly, lethargically, through it all. At the sheltered workshop a few miles away, two retarded adults boarded and sat next to the rambunctious ones, confining them to their seats. But arms and hands still flailed over seat backs, and the noise level remained deafening. I arrived home exhausted.

That was over 2 years ago. Since then all of us on the bus have evolved a system for making our bus a congenial place and our time together a constructive learning experience. We learn independence in taking care of ourselves and interdependence in assisting each other. We learn social and academic skills while we go on a daily field trip in our mobile classroom.

THE PASSENGERS

That first year I had 16 trainable retarded passengers ranging from 5 to 33 years old, from wheelchair ridden to athletic, from severely to moderately retarded. The group included the school behavior problems as well as its most retarded students. It took only that first return trip to persuade me that I could not handle the students' needs and the driving alone; yet, Ohio schools provide no aides on buses carrying handicapped passengers.

I approached Madeline and Steve, the young adults from the sheltered workshop and asked them if they would help. Would Madeline sit between Jennifer, who has cerebral palsy, and Charlene, who has epilepsy and severe retardation? Would she keep the younger ones from knocking them over? Would Steve lift Jennifer on and off the bus? Would he sit with Jack, a delightful but unpredictable Down's syndrome child, and involve him in some activity? Both Madeline and Steve were receptive, in fact eager to prove themselves.

We began by giving a job to anyone who was interested. Sonny, an 11 year old with Down's syndrome, and 6 year old Fran alternated sitting with Charlene. If Charlene had a tantrum, Madeline or Steve took over. Cindy and Judy took Jim's hands and led him off the bus and into school. Jack took responsibility for bringing Jennifer's wheelchair out to the bus. After Steve lifted Jennifer off the bus, Nadine or Tammy rolled her in to school.

RULES OF THE ROAD

We developed two basic rules: Nothing could be done that would be unsafe, which included walking or running around the bus and hanging out windows, and nothing could be done that might hurt someone, which included physical and verbal abuse. Because we could take any of several routes home, students could get off the bus on the way out to the end of the line or on the way back. Since parents were open to flexibility in afternoon arrival times, good behavior could earn the riding privilege, which all considered more fun than going straight home. Both Sonny and Fran responded well to riding around. Jack and Barbie, older and more set in their ways, loved to ride but never really stopped their hitting and name-calling.

During our rides we talked about our limitations: why Judy's cleft palate made her so hard to understand; how cerebral palsy affected Jennifer's ability to talk. We identified reasonable goals for each other. We agreed that whenever someone learned to do a new task we would offer cheers but would offer help only if necessary.

WORKING ON THE BUS

In the course of the year, students learned skills that were important to them. Six year old Fran mastered the complete process of blowing her nose, from realizing she needed to do it through depositing the crumpled tissue in the waste box. Madeline made flash cards to teach Judy and Sonny the alphabet. We decorated the bus with our artwork. We counted passing school buses and practiced addition as we picked people up and subtraction as we dropped them off. We worked on the days of the week, learned colors, and read clocks. We talked about mining as we passed coal fields; crops, animals, and seasonal changes as we passed farms, construction, and factories as we drove through towns. Madeline, Steve, Tammy, and I talked about marriage, children, and supporting a family, topics of great interest to them. After much drill, Barbie, a 33 year old epileptic with severe retardation, learned to say her telephone number and answer variations of "Where do you live."

Until last year severe cerebral palsy had kept 16 year old Jennifer home in her wheelchair. Now as the bus approaches, she jerks her shoulders enthusiastically and her chair jumps in response. During one ride Jennifer rolled her head back and let out a vibrant laugh. Look! Fran said as she held up Jennifer's unclamped seat belt. Fran grinned impishly at Jennifer and snapped the belt together again. Slowly Jennifer grated the knuckles of her hand across the

latch and again the belt fall apart on her lap. We all cheered.

Jennifer understands speech. We talked about wearing the belt. Would she keep the belt clamped during the ride? She nodded "Yes." Would she release it at the end of the ride so Steve could lift her off the bus? She jerked her head up and down enthusiastically. Jennifer had her job.

MEETING PROBLEMS

One of Charlene's tantrums tested our ability to handle a new problem. Even Charlene's mother, who gives Charlene a caring and secure home, cannot predict these outbursts. One moment Charlene will be sitting quietly, fondling her rubber ball. Then suddenly she screams, strikes out, and grabs blindly.

We were driving on a main highway at 50 miles an hour. Suddenly Charlene wailed, reached over snatched my hair, and yanked. My neck was jerked back against the top of the seat back, my chin pointing to the ceiling. I couldn't see the road and had trouble holding the steering wheel. Fran, who had been sitting with Charlene, darted up the aisle out of the way. As I eased on the brakes, Steve releaded Charlene's hands from my hair, and Madeline offered Charlene a Styrofoam cup as an alternative. Within seconds of the outburst Charlene was giggling happily as she pressed the spongy cup to her mouth.

We pulled off the road and talked about what to do. Should we move Charlene? She needed a seat belt, which meant a front seat. But so did several other people, one of whom had already pulled a parka hood over my face. We were discussing possible solutions when Charles, who is in the adult activities class for those unable to handle workshop responsibilities, learned forward, "Lady... Lady can I ask you a question?" "Sure, Charles." "Lady... Lady, why don't you tie your hair up?" So obvious, so workable a solution. Thereafter if I forgot to pin my hair up at Charlene's house, Charles would remind me.

And so the year moved swiftly past. Like a close family we took care of each other when necessary. We lived and grew together.

A NEW ROUTE

This year I have a different route with only nine passengers. The range in age, economic status, physical ability, and intelligence is the same but we have no unusual behavior problems. We work on the same principles as last year. Everyone teaches. We encourage each other to try new things and to move toward new skills.

Nelson, a workshop client, loves to take things apart, fix them, and then tell you what he did. He has the ability to hold a semi-skilled job but he needs guidance in social areas. I asked Nelson to work with Bruce and Jimmy on the bus.

COOPERATION--THE KEY

Bruce is big and strong for his 10 years. When he first came to school, he stomped around the classroom overturning desks. Bruce fears failure. He needs tasks hard enough to guarantee success. Nelson gave Bruce a bicycle lock and key ring with three keys isolated. Bruce found the proper key and opened the lock. Then Nelson jumbled the keys. When Bruce solved that problem, Nelson gave him a different lock and jumbled key ring.

Jimmy, a 10 year old, has cerebral palsy. He has little strength or dexterity in his hands. Nelson put a lock in Jimmy's right hand and properly positioned the key in his left hand. Jimmy struggled, finally aligned the key with the slot, pushed it in, and twisted. The lock responded with a clank. Jimmy was delighted. Gradually Nelson made Jimmy's task harder until on his own Jimmy could pick up the key, position it, and open the lock.

Jimmy, in fact, has progressed remarkably in a few months. Last year his mother lifted him on the bus and fastened his seat belt. Now Jimmy waits at the roadside by himself, pulls himself up the steps, and, once seated, clamps him own belt. After days of watching Bruce close the bus door before we left school, Jimmy came forward. For a moment I throught Bruce would not relinquish his job, but he stepped back quietly, Jimmy grabbed the handle with both hands and yanked as he had seen husky Bruce do. The handle moved only slightly. Jimmy pulled again. No results. "Get behind it, Jimmy," Bruce advised. Jimmy hobbled around the handle and pushed. Slowly the door closed.

Jimmy keeps trying and we keep encouraging him and asking for more. After he had enjoyed several days of two handed success, we began calling for him to open the door using only his left hand, then only his right. Now Jimmy has several jobs. He hands John his crutch after John is off the bus, starts the door closed with his left hand, and finishes the job with his right hand.

I have known Jimmy a long time before I realized that he never talked. He understood everything, but when he wanted something he would point, "Enh, enh," and someone satisfied his need. I tried to talk with Jimmy during the hour a day he and I were alone on the bus, but whenever he said something, which was seldom, I could not understand him. So Jimmy stared out one window, and I stared out another. Now, with Jimmy joining in, we sing ditties about skills he has learned:

I can put my seat belt on
I can put my seat belt on
I can put my seat belt on
I can, yes, I can.
I can close the big front door
I can....
I can say my telephone number
I can....

Through the music, Jimmy has relaxed so that he now talks more. And the more he talks, the clearer his speech becomes.

THE HOT ROD MUSIC BUS

Music is important on our bus. We sing so much that we call ourselves the Hot Rod Music Bus, a name suggested by Richard, a workshop client in his early 20's. Richard plays the guitar and with a little encouragement brought it along on the bus. Now he has declared Wednesday, "guitar day." Each Wednesday he brings his guitar and leads us in singing. Kathy, 13 years old, picks up new songs quickly and has a repertoire of her own. Bruce, Jimmy and John catch tune fragments and choruses on their kazoos.

We are really free with songs. We change songs if we want to, make up verses, make up songs about our bus, about each other, about the places we go, and the things we do. This has become an important teaching tool. I had made some flash cards with our telephone numbers on them in response to Jimmy's interest in learning his own number. Richard spotted the cards as soon as he climbed on the bus. He picked them up and made a song with each verse repeating a number and finally associating it with the person's name. Within a week Kathy, Sarah, and Jimmy knew their telephone numbers well enough for Richard to make purposeful mistakes. Then Kathy, Sarah, and Jimmy would boo, hiss, and protest in pleasure.

Music is also a marvelous tool for recognizing accomplishments. There is nothing like a song--a very special song just about you and something you are struggling with or have mastered--to make you feel good about yourself. The songs can be simple, short, and spontaneous. A song like the one about Jimmy buckling his seat belt (a great achievement), closing the door, or learning his telephone number guarantees enthusiasm for repeating the task and attempting new ones.

A BUS FULL OF TEACHERS

We all teach each other on the bus, and so I learn too. Music is an example. For years I was teased about my singing, so I stopped. I became embarrassed to sing, even in a group. But the people on the bus have taught me that not only is my singing acceptable, but it is also good fun. They have given me so much encouragement that I now learn new songs to teach them. I sing happily if not beautifully in other social groups and will even teach songs.

Sometimes we all work together on a concept. Bruce and Sarah knew left from right, but Kathy and John had only a 50-50 guessing chance. We figured out a way to remember which was which, then chorused directions on the way to school. Bruce agreed to check Kathy and John that afternoon.

"Which way do we turn at Hope's dairy, Kathy?"

"Right!"

"Now which way, John?"

"Right again!"

Several days later Bruce tested them again. "Which way do we turn at Poston Church?"

"Left!" Kathy and John chorused as we turned.

Kathy and John also work on the days of the week. Bruce and Kathy struggle with adding one digit numbers. Sarah works on letters. Jimmy concentrates on counting through the teens (he has the 20's, 30's, and 40's down pat). Richard and Nelson practice reading rode signs.

I try to help, but with eye contact limited to a rear view mirror and with hands and feet occupied by a steering wheel and pedals, I am largely confined to taking, suggesting, and encouraging from a distance. For example, when Robert appeared with a toy watch he could not read, I paired him up with Richard, who is fascinated by time. I talked with Richard about going slowly and saying "half past" and "quarter past" until Robert had completely mastered the hours. We made a cardboard clock with just an hour hand, and the two went to work. Several weeks later we added another hand and began talking about half hours. And so on. I kept out of the actual teaching through I felt it important to stimulate, encourage and guide.

THE TOOL BOX

We have other "tools" besides our clock in a large carton under the front seat. Some are actual tools; some are odds and ends from around the house. Many are toys from the school's toy lending library. I change the toys every few weeks, trying to keep in mind things we have been talking about and skills particular students need to work on. I try to have a puzzle or two, manual skill, toys and something to encourage following motion with the eyes.

Sometimes I race a student on a task. Yesterday Jeanie picked up a Playstool puzzle she had not tried in a while.

"You want to race, Jeanie?" I asked. "I'll race you to Sugar Creek."

"OK." Jeanie became absorbed in the puzzle. And she beat me.

We both know it is a game. And we both know that I will set a goal she can reach if, but only if, she puts her mind to it.

MAP YOUR ROUTE

It is important to me to keep the students' teachers informed about what we are doing. I try to spend a day or so every month observing classes so I can work consistently with the teachers. I let the teachers know what we are working on, tell them about successes so

they can reinforce them, and discuss problems with them. Our conversations are free flowing and easygoing, usually a few minutes each day as students arrive and leave.

I do not make formal lesson plans for our bus rides. However, I do keep in mind goals for each person and ways to reach them. I try to keep my eyes open for student interests I can build on and for new materials. Doing something creative during our 4 hours a day is important, important to students personally and important for their development, and it is important for me as an effective way to work with students.

A year ago, I started course work for certification to teach trainable retarded children. But I had second thoughts. In a classroom I would have a more homogeneous group than the range of passengers I enjoy on the bus. I would have lunch money, monthly progress reports, state records, and staff meetings to worry about. The Appalachian hills I love would remain outside, static, framed by a classroom window. I decided to stay with the Hod Rod Music Bus.

DISCUSSION GUIDE FOR THE FILM

"PROBLEMS IN TRANSPORTING THE HANDICAPPED"
27 minutes color sound

INTRODUCTION

"PROBLEMS IN TRANSPORTING THE HANDICAPPED" is a sister film to "LIFELINE TO LEARNING". Both of these films are designed to develop in the viewer an awareness of the difficult but necessary task of transporting special education students to and from school and other activities.

"PROBLEMS IN TRANSPORTING THE HANDICAPPED" stresses problem recognition and the importance of preplanned and prudent responses in transporting the special education student. It examines the serious medical and behavioral problems often encountered with special education students, and shows successful techniques used by drivers in solving these problems.

WHO IS THE FILM DESIGNED FOR ?

"PROBLEMS IN TRANSPORTING THE HANDICAPPED" is for:

* Bus drivers and transportation directors to be used as in-service training materials
* Educators in special education, transportation programs in universities, and community organizations
* Parents and teachers of special education students to create support and awareness of what goes on aboard the bus, and how very important the parent-driver, and teacher-driver relationships are for a successful program
* School board officials, legislators, and budget decision makers to make them aware of the need for special education transportation, and explain to them that though this specialized form of transportation is expensive, it is vital to the future of the special education student, and growth of the community

HOW IS THE FILM DESIGNED ?

The film is structured into four parts:

* Communication Problems
* Behavioral Problems
* Medical Problems
* Emergency Problems

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PROBLEMS IN TRANSPORTING THE HANDICAPPED

At the end of each section a question appears on the screen followed by black. The appearance of this question gives the instructor the opportunity to stop the projector and discuss with the audience the questions raised in the section. Additional questions and topics are included in this guide. We have not provided the answers to the questions as they will, for the most part, vary due to district and state policies. We encourage the instructor to use this technique of discussion with the film especially when the film is used in an in-service driver training program.

PART I: COMMUNICATION PROBLEMS

The film only shows the communication problems with the students, what about parents? Teachers? What should you say to them? How much should you say? When do you say it? With whose permission? What about CONFIDENTIALITY?

How would you communicate with a mentally handicapped youngster and ask him/her to stop doing something? A visually impaired youngster? A hearing handicapped youngster? An orthopedically handicapped youngster?

What are some of the "body signs" which the passengers use to communicate that you have noticed? What are they saying?

What are some of your "body signs" which you might not be aware of but your passengers might be?

How do you tread the narrow road between showing compassion and having the passenger become emotionally dependent upon you?

Will the relationship you establish with the passsenger threaten the teacher? Parent?

Where can you get helpful information about the passenger to assist in improving communications?

What kinds of information should you communicate to your passengers?

What are the various ways we communicate?

How do you know that you have successfully communicated?

PART II: BEHAVIORAL PROBLEMS

What problems will you face?

What preplanned response will you have?

When reprimanding a child "one-on-one" how can you make this confrontation educational for the other passengers as well?

What special problems are there in handling a 16 year old whose mental development is only that of a 5 year old? What risks are there in treating him/her like a 5 year old? On what level should you communicate?

What are some forms of self-abusive behavior? What should you do to stop it? To whom and when do you report it?

What are the proper channels to handle severe discipline problems?

When do you mention the behavioral problems on the bus to parents? Teachers? Other drivers?

What is your moral and legal obligation for confidentiality?

PROBLEMS IN TRANSPORTING THE HANDICAPPED

How do you successfully set rules and guidelines for the mentally handicapped passenger? Visually impaired? Hearing handicapped? Orthopedically handicapped?
How do you know that they understand them?
How often should you go over them?
With aides (or bus assistants), if there is a disagreement with the driver, how, when, and by whom is it resolved?
How do you identify the "good" child to reinforce good behavior?
What are the problems which a substitute driver will have with a reward system used by the regular driver? How can they be alleviated?
What is right and what is wrong with a reward system?
Why do sexual problems occur? Are they embarrassing? How should you handle them?
What do you do when a passenger runs off the bus?
What are the various methods suggested for handling behavioral problems? (Possible Answer: flexibility, firmness, delegating responsibility, giving praise in isolation, and rewarding the sutdent, i.e. playing the radio.)
What is the root of some of the behavioral problems you have experienced?

PART III: MEDICAL PROBLEMS

How can you protect an allergic passenger from smog or pollen?
Which of your passengers are hyper-sensitive? Is it to touch? Temperature? Smell? How can you reduce the chances that this hyper-sensitivity will "set the passenger off"?
Who should be responsible to see that the child is properly dressed?
What are the potential dangers in the child being over-dressed? Under-dressed?
Do you know mouth-to-mouth resuscitation or CPR (cardio-pulmonary resuscitation) techniques?
If you have a health and medical card on board, how do you maintain confidentiality?
What information should be on a health and medical card?
How often should it be updated? By whom? Who is responsible to see that it is done?
When do you rely on the card instead of checking with the transportation office?
Why is it important to have a picture of the passenger on the card? (Possible Answer: so that no mistake is made, especially with substitute drivers.)
What are the special responsibilities and liabilities that come with transporting medication? What steps can be taken to reduce the risk?
Do you know the construction and operation of the wheelchairs and braces used by any orthopedically handicapped passenger you transport?
What preplanning have you done for a medical emergency?

PROBLEMS IN TRANSPORTING THE HANDICAPPED

Do you know the fastest source of emergency assistance at all points along the route?
Do you know all important emergency telephone numbers?
How do you request emergency assistance from a passer-by so that they can calmly and quickly carry out your request?

PART IV: EMERGENCY PROBLEMS

What are the district policies in evacuating the bus?
When should you evacuate the bus? Who decides?
Which passengers do you get out first? Last?
Do you have passengers who can be leaders? Have you worked with them to prepare them to help you in an evacuation?
Have any of the passengers been taught to use emergency equipment? If so, when should they be permitted to use it? (Possible Answer: only to assist in the evacuation or to prolong the time available for evacuation. NEVER as a substitute for evacuation.)
What will you say and do in any emergency? To the passenger? To bystanders?
Do you have sufficient drills so that even the mentally handicapped passengers will know how to react?
Why is it necessary to pick out one spot to assemble? (Possible Answer: to keep them from wandering.) How do you mark or describe that spot?
What special evacuation challenges are presented by mentally handicapped passengers? Visually handicapped? Hearing handicapped? Orthopedically handicapped? What are the solutions to these challenges?
Does your police and fire department know the physical structure of your bus and the nature of your passengers and understand their limitations?
What would your response be to a passenger having a seizure?
Should you stop the bus immediately? What are the risks of doing so?
Is the seizure really dangerous? If so, to whom? What steps can be taken to reduce any danger which may exist?
Should you become fixated on one passenger at the expense of the others?
When and to whom should a seizure be reported?

FORMS

On the following page are copies of forms which the producers found useful and thought might be of interest to users of this film. They are probably not complete but should serve as a good starting place for users wishing to know more about some of the suggestions made in the film.

PROBLEMS IN TRANSPORTING THE HANDICAPPED

HOW CAN YOU HELP US TO BETTER SERVE YOU ?

We want to produce the best possible materials for you so that you can get your job done effectively, and successfully. To this end we enclose an evaluation sheet with each film. If you have one we would appreciate your taking a minute to fill it out and send it back to use, or with the film back to us.

We need to know your needs and ideas to produce effective instructional materials. Please write us, phone us, or talk with us at meetings. Tell us what you like, or even dislike about our materials. Tell us what you need, and what you would like to see developed. Help us to help you. Thanks.

Dr. David W. Parker

Ms. Victoria Clinton

Mr. Hugh Kennedy Tirrell

Mr. Richard Buckley

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(continued from inside front cover)

Topical Manuals

___ Volume III-A: Individual Educational Programs, 1980.

___ Volume III-B: Evaluating the Non-English Speaking Handicapped, 1982.

___ Volume III-C: Mediation and Due Process Procedures, 1982.

___ Volume III-D: Maintaining Education Records of Pupils and Adult Students, 1982.

___ Volume III-E: Alternative Communication Systems for Non-Vocal Students, 1982.

___ Volume III-F: Electronic Communication Devices for Visually Impaired Students, 1982.
___ Part 2: Computer Accessibility for the Visually Impaired, 1983.

___ Volume III-G: Alternative Delivery Systems for Homebound/Hospitalized Students, 1982.

___ Volume III-H: Supplement User's Guide AAMD ABS-PSV, 1981.

___ Volume III-I: Computer Assisted Instruction and Support for the Handicapped: Interim Report, 1982.

___ Volume III-J: Interagency Service Plans for the Profoundly Mentally Handicapped, 1983.
___ Part 2: Partners in Planning: A Planning Guide, 1983.
___ Part 3: Partners in Planning: A Participant's Manual, 1983.

Training Manuals

___ Volume IV-A: Training Manual for School Bus Drivers Transporting the Handicapped, 1982.

___ Volume IV-B: A Training Manual for Teachers of the Homebound/Hospitalized Student, 1980.

___ Volume IV-C: A Training Manual for the Development of a Home/School Information System, 1983.

___ Volume IV-D: Educating Parents of the Severely Emotionally Disturbed, 1983.
___ Part 2: An Annotated Bibliography, 1983.

___ Volume IV-E: Management of Eligibility and Placement Processes, 1983.

___ Volume IV-F: Parent Involvement Program for Emotionally Handicapped Students, 1983.

___ Volume IV-G: Positive Discipline for Exceptional Students, 1983.

Curriculum Planning Resources

___ Volume V-A: Curriculum Planning Resource Manual for Developmental Skills and Communication Skills; Hearing Impaired: Deaf and Hard of Hearing, 1977.

___ Volume V-B: MODELL: Music or Drama to Enhance Language Learning, 1982.

___ Volume V-C: Affective Curriculum for Secondary Emotionally Handicapped Students, 1983.

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State of Florida
Department of Education
Tallahassee, Florida
Ralph D. Turlington, Commissioner
Affirmative action/equal
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FLORIDA: A STATE OF EDUCATIONAL DISTINCTION. "On a statewide average, educational achievement in the State of Florida will equal that of the upper quartile of states within five years, as indicated by commonly accepted criteria of attainment."